RESOURCE AND PATIENT MANAGEMENT SYSTEM

Emergency Room System (AMER)

User Manual

Version 2.5
July 2003

Information Technology Support Center
Division of Information Resources
Albuquerque, New Mexico

PREFACE

The purpose of this manual is to provide you with the information you need to appropriately understand and use the Emergency Room system. The ER package is designed to provide facilities with a tool that will help them better run and manage their Emergency Room.

This manual contains reference information about the ER package, examples of its processes, and procedures by which you can perform the activities supported by the package.

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1.0 Introduction

The IHS Emergency Room system captures ER data in two stages: admission and discharge. Admission data is stored in the ER ADMISSION file until the patient is discharged. Discharge info is stored in the ER VISIT file. Once the visit has been created the visit data is passed to the Visit, V POV and V Provider file. There is also a triage function that can be used to track the patient through the emergency room process.

The IHS Emergency Room system is a tool that will allow facilities to better run and manage their Emergency rooms. With the Emergency Room system, you can register, admit, and discharge patients. This package allows you to run a broad range of reports that will help you to see and manage the flow of patients and the staff workload.

2.0 Admit to Emergency Room (IN)

This option is used to admit an established patient into the Emergency room and is a data collection session for patients who are admitted to ER. Also, you can register a new patient, print a health summary, and add a patient to the ER ADMISSION file.

Admitting a patient to the ER

1. Type IN at the "Select Emergency Room System Option:" prompt.

```
                  ******************************************
                  *          Emergency Room System         *
                  *          Indian Health Service         *
                  *               Version 2.5              *
                  ******************************************

                              DEMO HOSPITAL


   IN     Admit to Emergency Room
   TRI    Triage Nurse Update Admission Record
   BAT    Batch Mode ER Admission/Discharge
   OUT    Discharge from Emergency Room
   DNA    Cancel Visit (did not answer or left AMA)
   DOA    DOA Admission to ER
   REG    Mini-Registration of New Patients
   SCAN   Scan Patient Names or Chart Numbers
   HERE   List Patients Currently Admitted to ER
   INST   Patient Instruction Menu ...
   RPTS   Reports Menu ...
   UP     Update '.9999' ICD9 codes
   EXP    Export data Menu ...
   PAR    Table and Parameter Setup ...


Select Emergency Room System Option:    IN
```

Figure 2-1: Admitting an ER patient (step 1)

2. Type the Patient's name or Chart number at the "Enter the Patient's Name or Local Chart Number:" prompt.

3. The system will display appointment information, if any, for the patient.

4. Type the date and time of the admission at the "Date and Time of Admission to ER:" prompt. If the admission is now, you may press the Return key to accept the default of *NOW*.

```
ER SYSTEM Ver 2.5: ADMISSION TO EMERGENCY ROOM      ^ = back up     ^^ = quit
Questions preceded by a '*' are optional.  Enter '??' to see choices.
~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~

Enter the patient's NAME or LOCAL CHART NUMBER:  DOE,JOHN    M 01-01-1901
000748159       33123

NO PENDING APPOINTMENTS

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Date and time of admission to ER:  NOW// [RET]  (MAY 27, 2003@11:58)

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```

Figure 2-2: Admitting an ER patient (steps 2-4)

5. Type the patient's presenting complaint at the "Presenting Complaint:" prompt. This field is free text and can take up to 80 characters.

6. The system will display a history of the patient's previous registrations and demographic information. You may edit the registration information at this time.

7. Type the type of visit at the "Visit Type:" prompt. You can select from First, Scheduled, or Unscheduled Revisit.

8. If your scheduling package has the Emergency room clinic set up. You will be prompted for a number of responses, appointment time, clinic, provider, and routing slips. You do no need to answer all questions. This will set up the appointment in the scheduling package and add information to the Visit file and V Provider file if responded to.

9. Type Y or N at the "Was this patient transferred from another facility?" prompt. If you type Y, you will be prompted to enter the name of the facility from where the patient was transferred and if a Medical attendant present during transfer.

10. Type how the patient traveled to the ER at the "Mode of transport to the ER:" prompt. Type ?? to see a list of available options. Depending on the option that you select, you may be prompted for specific information regarding the transportation method.

11. The system will display `ER admission data collection is now complete. Thank you.` when the admission is complete.

```
Presenting complaint: HEART ATTACK

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     DATE OF LAST REG. UPDATE:  FEB 27, 2002

PO BOX 123
ANYTOWN, NEW MEXICO  87528
NONE (home)  NONE (work)

WANT TO EDIT REGISTRATION RECORD? NO//


~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~

Visit type (FIRST, SCHEDULED, UNSCHEDULED REVISIT): FIRST VISIT// UNSCHEDULED
REVISIT

Creating Walk-in Appointment & Requesting Chart. . .
  (Type in ^ to bypass Check-In Process)

APPOINTMENT TIME: NOW//   (MAY 27, 2003@11:58)
APPOINTMENT AT 1158 ON 05/28/03 IN EMERGENCY ROOM

CHECKED-IN: NOW//   (MAY 27, 2003@11:58)
CLINIC CODE for VISIT: EM EMERGENCY MEDICINE       30
VISIT PROVIDER:    (MAY 27, 2003@11:58)
Visit Created.

OTHER INFO:
WANT TO PRINT ROUTING SLIP NOW? YES// NO
LABEL PRINTER: LER// ^


~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~

*Was this patient transferred from another facility? NO

~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~

Mode of transport to the ED: PRIVATE VEHICLE/WALK IN// [RET]

ER admission data collection is now complete.  Thank you.
```

Figure 2-3: Admitting an ER patient (steps 5-11)

3.0 Triage Nurse Update Admission Record (TRI)

This option enables the triage nurse to edit the ER admission record before the transaction is processed. Record the time the patient was seen by the Triage Nurse, Admitting Provider and initial acuity by the Nurse.

Updating the Admission Record

1. Type TRI at the "Select Emergency Room System Option:" prompt.

```
                  ******************************************
                  *          Emergency Room System         *
                  *          Indian Health Service         *
                  *               Version 2.5              *
                  ******************************************

                             DEMO HOSPITAL


   IN     Admit to Emergency Room
   TRI    Triage Nurse Update Admission Record
   BAT    Batch Mode ER Admission/Discharge
   OUT    Discharge from Emergency Room
   DNA    Cancel Visit (did not answer or left AMA)
   DOA    DOA Admission to ER
   REG    Mini-Registration of New Patients
   SCAN   Scan Patient Names or Chart Numbers
   HERE   List Patients Currently Admitted to ER
   INST   Patient Instruction Menu ...
   RPTS   Reports Menu ...
   UP     Update '.9999' ICD9 codes
   EXP    Export data Menu ...
   PAR    Table and Parameter Setup ...


Select Emergency Room System Option:    TRI
```

Figure 3-1: Updating the Admission Record (step 1)

2. The system will display a list of all patients currently admitted to the ER.

3. Type the number that corresponds to the patient you are adding triage information for at the "Select ER Patient:" prompt.

4. Type Emergency or Urgent at the "Clinic type (EMERGENCY or URGENT):" prompt.

5. Type the name of the admitting provider at the "Admitting Provider:" prompt. Type ?? to see a list of providers or press the Return key to bypass this field. If an Admitting Provider is entered you will be prompted for the time patient was seen by Provider.

6. Type the name of the triage nurse at the "Triage Nurse:" prompt. Type ?? to see a list of providers or press the Return key to bypass this field. If a Triage

Nurse is entered you will be prompted for the time patient was seen by Triage Nurse.

```
The following patients are currently admitted to the ER =>

   NAME          DOB           CHART    ADMISSION          PRESENTING COMPLAINT
-------------------------------------------------------------------------------
1) DOE,JOHN      JUN 01,1901  33574    MAY 30,2003@10:45  PAIN
2) RABBITT,BUD   JAN 01,1901   123     MAY 27,2003@12:13  Heart Attack
3) FUDD,ELMER    DEC 01,1901  84877    MAY 27,2003@14:33  heart

Select ER patient: 1  DOE,JOHN
  DOE,JOHN                          M 06-01-1901 000748159       33574

~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~

ER ADMISSION FOR DOE,JOHN    ^ = back up    ^^ = quit
The answers to ALL questions, except those marked with a '*', are MANDATORY!
~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~

Clinic type (EMERGENCY or URGENT): EMERGENCY MEDICINE        30

~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~

*Admitting provider: PROVIDER,JOE       JAC          Physician

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*Triage nurse: ADAM,ADAM     AA

~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~
```

Figure 3-2: Updating the Admission Record (steps 2-6)

7. Type the number that corresponds to the initial triage assessment from the triage nurse at the “Enter initial triage assessment from RN:” prompt.

8. Type the time that triage nurse saw the patient at the “What time did the patient see the triage nurse:” prompt or press the Return key to bypass this field. If the time was several hours from the time of admission, the system will ask for confirmation on the time.

9. Type the time that doctor saw the patient at the “What time did the patient see the admitting doctor:” prompt or press the Return key to bypass this field. If the time was several hours from the time of admission, the system will ask for confirmation on the time.

```
Enter initial triage assessment from RN:  (1-5): // 1

~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~

*What time did the patient see the triage nurse:  5p  (JUN 03, 2003@17:00)

This means a really long delay since the time of admission: MAY 30,2003@10:45
Are you sure? No// y  (Yes)

~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~

*What time did the patient see the admitting doctor:  6p  (JUN 03, 2003@18:00)

This means a really long delay since the time of admission: MAY 30,2003@10:45
Are you sure? No// y  (Yes)

~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~
```

Figure 3-3: Updating the Admission Record (steps 7-9)

10. The system will display a summary of the patient's admission and triage information. Review the summary for accuracy.

11. Type Y or N at the "Do you want to make any changes?" prompt.

    a. If you type No, then type Y or N at the "Do you want to print patient instructions?" prompt. The discharge is complete and the system will display `Data entry session successfully completed...Thank you`.

    b. If you type Yes, continue through step 14.

12. The system will then allow you to reenter responses to the admission and triage prompts. Type the new information at the prompts.

13. When you are done typing responses to the prompts, the system will redisplay the patient's summary, allowing you make further changes to information.

14. When you are done making changes to the discharge, type NO at the "Do you want to make any changes?" prompt.

```
Summary of this ER data entry session for JOHN DOE =>
                    ---  ADMISSION SUMMARY  ---
Patient: DOE,JOHN                   Arrival time: MAY 30,2003@10:45
Presenting Complaint: PAIN              Visit type: FIRST VISIT
Transferred from:
Transport to ED: PRIVATE VEHICLE/WALK IN
Ambulance ID:                           Ambulance billing #:
Ambulance company:                      Clinic type: EMERGENCY MEDICINE
Admitting provider: PROVIDER,JOE         Triage nurse: ADAM,ADAM
Initial triage category: 1
Seen by triage nurse at: JUN 3,2003@17:00
Seen by admitting provider at: JUN 3,2003@18:00

Do you want to make any changes? No// NO  (No)
~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~
```

Figure 3-4: Updating the Admission Record (steps 10-14)

4.0 Batch Mode ER Admission/Discharge (BAT)

This option allows you to enter both admission and discharge information.

Using the Batch Mode option

1. Type BAT at the "Select Emergency Room System Option:" prompt.

2. Type the patient's name or chart number at the "Enter the patient's Name or Local Chart Number:" prompt.

3. The system will take you through a series of prompts asking for Admission information, see section 2.0 Admit to Emergency Room (IN) for more details.

4. The system will then take you through a series of prompts asking for Discharge information, see section 5.0 Discharge from Emergency Room (OUT) for more details.

```
   IN     Admit to Emergency Room
   TRI    Triage Nurse Update Admission Record
   BAT    Batch Mode ER Admission/Discharge
   OUT    Discharge from Emergency Room
   DNA    Cancel Visit (did not answer or left AMA)
   DOA    DOA Admission to ER
   REG    Mini-Registration of New Patients
   SCAN   Scan Patient Names or Chart Numbers
   HERE   List Patients Currently Admitted to ER
   INST   Patient Instruction Menu ...
   RPTS   Reports Menu ...
   UP     Update '.9999' ICD9 codes
   EXP    Export data Menu ...
   PAR    Table and Parameter Setup ...


Select Emergency Room System Option:    BAT  Batch Mode ER Admission/Discharge
ER SYSTEM Ver 2.5: ADMISSION TO EMERGENCY ROOM      ^ = back up     ^^ = qu
it
Questions preceded by a '*' are optional.  Enter '??' to see choices.

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Enter the patient's NAME or LOCAL CHART NUMBER: DOE,JANE
         F 08-01-1901 000351866       22222

NO PENDING APPOINTMENTS

~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~
Date and time of admission to ER:  // NOW  (MAY 30, 2003@09:52)
~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~
Presenting complaint: HEART ATTACK
~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~
     DATE OF LAST REG. UPDATE:  APR 22, 2003

GENERAL DELIVERY
ANYWHERE, NEW MEXICO  87528
NONE (home)  NONE (work)

~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~
Visit type (FIRST, SCHEDULED, UNSCHEDULED REVISIT): FIRST VISIT// [RET]
~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~
*Was this patient transferred from another facility? NO//[RET]
~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~
Mode of transport to the ED: PRIVATE VEHICLE/WALK IN//[RET]
~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~
Clinic type (EMERGENCY or URGENT): EMERGENCY MEDICINE// [RET]       30
~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~
*Admitting provider: PROVIDER,JOE       JAC          Physician
~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~
*Triage nurse: ADAM,ADAM     AA
~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~
Enter initial triage assessment from RN:  (1-5): // 1
~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~
*What time did the patient see the triage nurse: [RET]
~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~
*What time did the patient see the admitting doctor: [RET]
~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~
Was this ER visit caused by an injury? NO//[RET]
~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~
```

```
Was there a positive lab screen for ALCOHOL and/or DRUG ABUSE? NO//[RET]
~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~
Was this ER visit WORK-RELATED? NO//[RET]
~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~
Enter procedure: NONE//[RET]
~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~
Enter narrative description of  the PRIMARY diagnosis: HEART PROBLEMS
Enter ICD9 code: .9999//  [RET]  .9999     UNCODED DIAGNOSIS    UNCODED
DIAGNOSIS
         ...OK? Yes// [RET]  (Yes)

Enter another diagnosis: [RET]
~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~
Enter final acuity assessment from provider:  (1-5): // 2
~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~
Disposition: HOME
~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~
*Follow up instructions: RTC PRN, INSTRUCTIONS GIVEN//[RET]
~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~
Provider who signed PCC form: PROVIDER,JOE// [RET]       JAC         Physician
~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~
Discharge nurse: ADAM,ADAM     AA
~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~

What time did the patient depart from the ER:  NOW//   (MAY 30, 2003@09:53)
Summary of this ER data entry session for JANE DOE =>
                    ---  ADMISSION SUMMARY  ---
Patient: DOE,JANE              Arrival time: MAY 30,2003@09:52
Presenting Complaint: heart attack      Visit type: FIRST VISIT
Transferred from:
Transport to ED: PRIVATE VEHICLE/WALK IN
Ambulance ID:                           Ambulance billing #:
Ambulance company:                      Clinic type: EMERGENCY MEDICINE
Admitting provider: PROVIDER,JOE         Triage nurse: ADAM,ADAM
Initial triage category: 1              Seen by triage nurse at:
Seen by admitting provider at:
                    ---  CAUSE OF VISIT  ---
Related substances:                     Occupation related: NO
Occupation:                             Industry:
                    ---  INJURY INFORMATION  ---
Injury related visit: NO                Trauma surgeon notified:
Trauma surgeon time:                    Location:
Time of injury:                         Cause of injury:
Setting:                                Safety equipment:
What happened:
                    ---  ER PROCEDURES  ---
Procedures: NONE
                    ---  EXIT ASSESSMENT  ---
Diagnoses: heart problems [.9999]       Discharge acuity: 2
                    ---  DISPOSITION  ---
Disposition: HOME                       Transfer to:
                    ---  DISCHARGE INFO  ---
Provider who signed PCC form: PROVIDER,JOE
Discharge nurse: ADAM,ADAM              Departure time: MAY 30,2003@09:53
                    ---  FOLLOW UP INSTRUCTIONS  ---
Discharge instructions: RTC PRN, INSTRUCTIONS GIVEN


Do you want to make any changes? No// [RET]  (No)
```

Figure 4-1: Using the BAT option

5.0 Discharge from Emergency Room (OUT)

This option is a data collection session for patients who are discharged from ER. This info is stored in the ER VISIT file. Also, you can print patient instructions, create a visit and remove patients from the ER admission file.

Use this option to discharge a patient from the Emergency Room. The answers to All questions, except those marked with a '*', are Mandatory.

Discharging a patient from the ER

1. Type OUT at the "Select Emergency Room System Option:" prompt.

```
   IN     Admit to Emergency Room
   TRI    Triage Nurse Update Admission Record
   BAT    Batch Mode ER Admission/Discharge
   OUT    Discharge from Emergency Room
   DNA    Cancel Visit (did not answer or left AMA)
   DOA    DOA Admission to ER
   REG    Mini-Registration of New Patients
   SCAN   Scan Patient Names or Chart Numbers
   HERE   List Patients Currently Admitted to ER
   INST   Patient Instruction Menu ...
   RPTS   Reports Menu ...
   UP     Update '.9999' ICD9 codes
   EXP    Export data Menu ...
   PAR    Table and Parameter Setup ...


Select Emergency Room System Option:     OUT  Discharge from Emergency Room
```

Figure 5-1: Discharging an ER patient (step 1)

2. The system will display a list of all patient's currently admitted to the ER.

3. Type the number that correspond to the patient you are discharging at the "Select ER Patient:" prompt.

4. Type Emergency or Urgent at the "Clinic type (EMERGENCY or URGENT):" prompt.

5. Type the name of the admitting provider at the "Admitting Provider:" prompt. Type ?? to see a list of providers or press the Return key to bypass this field. If the information was entered during the triage session, it will be displayed at this prompt.

6. Type the name of the triage nurse at the "Triage Nurse:" prompt. Type ?? to see a list of providers or press the Return key to bypass this field. If the information was entered during the triage session, it will be displayed at this prompt.

```
The following patients are currently admitted to the ER =>

   NAME           DOB          CHART    ADMISSION        PRESENTING COMPLAINT
------------------------------------------------------------------------------
1) DOE,JOHN      JUN 01,1901  33574    MAY 27,2003@11:58  heart attack
2) DOE, JANE     SEP 01,1901  65441    MAY 27,2003@14:34  pain
3) RABBITT,BUD   JAN 01,1900  12123    MAY 27,2003@12:13  Heart Attack
4) FUDD,ELMER    DEC 01,1904  84877    MAY 27,2003@14:33  heart

Select ER patient: 1 DOE,JOHN
  DOE,JOHN                         M 06-01-1901 000748159       33123

~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~


ER ADMISSION FOR DOE,JOHN    ^ = back up    ^^ = quit
The answers to ALL questions, except those marked with a '*', are MANDATORY!
~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~

Clinic type (EMERGENCY or URGENT): EMERGENCY MEDICINE

~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~

*Admitting provider: PROVIDER,JOE               Physician

~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~

*Triage nurse: ADAM,ADAM     AA

~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~
```

Figure 5-2: Discharging an ER patient (steps 2-6)

7. Type the number that corresponds to the initial triage assessment from the triage nurse at the "Enter initial triage assessment from RN:" prompt. If the information was entered during the triage session, it will be displayed at this prompt.

8. Type the time that triage nurse saw the patient at the "What time did the patient see the triage nurse:" prompt or press the Return key to bypass this field. If the time was several hours from the time of admission, the system will ask for confirmation on the time. If the information was entered during the triage session, it will be displayed at this prompt.

9. Type the time that doctor saw the patient at the "What time did the patient see the admitting doctor:" prompt or press the Return key to bypass this field. If the time was several hours from the time of admission, the system will ask for confirmation on the time. If the information was entered during the triage session, it will be displayed at this prompt.

```
Enter initial triage assessment from RN:  (1-5): // 1

~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~

*What time did the patient see the triage nurse:  5p  (MAY 27, 2003@17:00)

This means a really long delay since the time of admission: MAY 27,2003@11:58
Are you sure? No// YES  (No)

~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~

*What time did the patient see the admitting doctor: 6p (MAY 27, 2003@14:00)

~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~
```

Figure 5-3: Discharging an ER patient (steps 7-9)

10. Type Y or N at the "Was This ER Visit Caused by an Injury?" prompt. If you typed No, skip to step 15. If you typed Yes, continue to step 11. If Yes, you will also be asked for surgeon and time patient was seen by the surgeon.

11. Type the town where the injury occurred at the "Town/Village Where Injury Occurred:" prompt. This is an optional field, you may press the Return key to bypass this field.

12. Type the Time and Date the Injury Occurred at the "Enter the exact time and date of Injury:" prompt. This is an optional field, you may press the Return key to bypass this field.

13. Type the cause of the injury at the "Cause of Injury:" prompt. Type ?? to see a list of available options.

14. Each cause of injury will prompt different questions. Please follow the prompts as they appear on your screen. Remember, if a question has an asterisk (*) next to it, you may press the Return key to skip the question.

```
Was this ER visit caused by an injury? NO// Y  YES
*Town/village where injury occurred: // DULCE
*Enter the exact time and date of injury:  052703@10a  (MAY 27, 2003@10:00)
Cause of injury: motor VEHICLE

*Setting of accident/injury: HIGHWAY OR ROAD
**Safety equipment used: AIR BAG
*Location of MVC: 1st and main
*Driver's insurance company: STATE FARM
*Driver's insurance policy number: 123
*Owner of vehicle (if different than driver): [RET]
*Owner's insurance company: [RET]
*Owner's insurance policy number: [RET]
*Was a second vehicle involved? NO// Y  YES
*Second vehicle driver: JOE, JOE
*Second vehicle driver's insurance company: ALLSTATE
*Second vehicle driver's insurance policy number: [RET]
*Second vehicle owner (if different than driver): [RET]
*Brief description of what happened: ACCIDENT
```

Figure 5-4: Discharging an ER patient (steps 10-14)

15. Type Y or N at the "Was there a positive lab screen for Alcohol and/or Drug Abuse?" prompt. If you type Y, you will be prompted to answer a few questions related to the lab tests:

    a. Type what the first test tested positive for at the "Lab Screen positive for:" prompt. Type ?? for a list of available options.

    b. If you typed Alcohol, you will be prompted to enter the blood level at the "Blood alcohol level (mg/dl):" prompt.

    c. If there was more than one substance that was positive, type the next substance at the "and LAB SCREEN positive for:" prompt.

    d. When you are done entering test, press the Return key at a blank "and LAB SCREEN positive for:" prompt to continue with the discharge.

16. Type Y or N at the "Was this ER visit Work-Related?" prompt. If you type Y, you will be prompted to answer a few questions related to the visit.

    a. Type Occupation or subsistence at the "Occupation or subsistence activity:" prompt.

    b. Type what kind of industry the patient is involved in at the "Industry:" prompt.

17. Type Y or N at the "Was the Trauma Surgeon Notified:" prompt. If you type Y, you will be prompted to enter the time the Surgeon saw the patient.

```
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Was there a positive lab screen for ALCOHOL and/or DRUG ABUSE? NO// Y  YES
LAB SCREEN positive for: ALCOHOL
Blood alcohol level (mg/dl):  (0-999): 10
and LAB SCREEN positive for: [RET]

~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~

Was this ER visit WORK-RELATED? NO// Y  YES
*Occupation or subsistance activity: // [RET]
*Industry: // [RET]

~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~

*Was the TRAUMA SURGEON notified? NO// [RET]

~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~
```

Figure 5-5: Discharging an ER patient (steps 15-17)

18. Type the type of procedure the patient had at the "Enter Procedure:" prompt. Type ?? to display a list of available options or press the Return key to accept the default of *NONE*.

19. Type another procedure at the "Enter Another Procedure:" prompt or press the Return key if there are no other procedures.

20. Type a description of the Primary diagnosis at the "Enter Narrative Description of the Primary Diagnosis:" prompt. This is free text.

21. Type the ICD code at the "Enter ICD9 Code:" prompt.

22. Type another diagnosis at the "Enter Another Diagnosis:" prompt, or press the Return key if there are no further diagnosis.

23. Type the number of the patient's final acuity assessment at the "Enter Final Acuity Assessment from Provider:" prompt.

24. Type the patient's disposition at the "Disposition:" prompt. Type ?? to display a list of available dispositions.

```
Enter procedure: NONE// BLOOD TRANSFUSION
Enter another procedure: [RET]

~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~

Enter narrative description of  the PRIMARY diagnosis: CAR ACCIDENT
Enter ICD9 code: 234.0
Enter another diagnosis: [RET]

~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~

Enter final acuity assessment from provider:  (1-5): // 2

~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~

Disposition: HOME

~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~
```

Figure 5-6: Discharging an ER patient (steps 18-24)

25. Type the follow up instructions at the "Follow up Instructions:" prompt.

26. Type the name of the Provider who signed the PCC form at the "Provider who Signed PCC Form:" prompt.

27. Type the name of the discharge nurse at the "Discharge Nurse:" prompt.

28. Type the time patient departed from the ER at "What time did the patient depart from the ER:" prompt. The time must be after the time of the triage for the computer to accept your response.

```
*Follow up instructions: RTC PRN, INSTRUCTIONS GIVEN// [RET]

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Provider who signed PCC form: PROVIDER, JOE//                  Physician

~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~

Discharge nurse: ADAM,ADAM     AA

~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~

What time did the patient depart from the ER:  NOW// 4p  (MAY 27, 2003@16:00)
```

Figure 5-7: Discharging an ER patient (steps 25-28)

29. The system will display a summary of the patient's discharge information. Review the summary for accuracy.

30. Type Y or N at the "Do you want to make any changes?" prompt. If you type No, the discharge is complete and the system will display `Data entry session successfully completed...Thank you`. If you type Yes, continue to step 31.

```
Summary of this ER data entry session for JOHN DOE =>
                    ---  ADMISSION SUMMARY  ---
Patient: DOE,JOHN                   Arrival time: MAY 27,2003@11:58
Presenting Complaint: heart attack      Visit type: UNSCHEDULED REVISIT
Transferred from:
Transport to ED: PRIVATE VEHICLE/WALK IN
Ambulance ID:                           Ambulance billing #:
Ambulance company:                      Clinic type: EMERGENCY MEDICINE
Admitting provider: PROVIDER, JOE       Triage nurse: ADAM,ADAM
Initial triage category: 1
Seen by triage nurse at: MAY 27,2003@13:00
Seen by admitting provider at: MAY 27,2003@14:00
                    ---  CAUSE OF VISIT  ---
Related substances: ALCOHOL             Occupation related: YES
Occupation: occ                         Industry:
                    ---  INJURY INFORMATION  ---
Injury related visit: YES               Trauma surgeon notified: NO
Trauma surgeon time:                    Location: dulce
Time of injury: MAY 27,2003@10:00       Cause of injury: MOTOR VEHICLE
Setting: HIGHWAY OR ROAD                Safety equipment: AIR BAG
What happened: accident
                    ---  ER PROCEDURES  ---
Procedures: BLOOD TRANSFUSION
                    ---  EXIT ASSESSMENT  ---
Diagnoses: car accident [234.0]         Discharge acuity: 3
                    ---  DISPOSITION  ---
Disposition: HOME                       Transfer to:
                    ---  DISCHARGE INFO  ---
Provider who signed PCC form: PROVIDER,JOE
Discharge nurse: ADAM,ADAM              Departure time: MAY 27,2003@16:00
                    ---  FOLLOW UP INSTRUCTIONS  ---
Discharge instructions: RTC PRN, INSTRUCTIONS GIVEN
                    ---  MOTOR VEHICLE COLLISION INFO  ---
Accident location: 1st and main         Driver insurance: state farm
Driver policy no.: 123                  Vehicle owner: same
Owner insurance co: same                Owner policy no.: 123
Second vehicle involved: YES            Driver #2: joe, joe
Driver #2 insurance co: allstate        Driver #2 policy no: 456
Owner #2:                               Owner #2 insurance co:
Owner #2 policy no.:


Do you want to make any changes? No// Y  (Yes)
```

Figure 5-8: Discharging an ER patient (steps 29-30)

31. Type the number of the section that you would like to edit at the "Which section do you want to edit:" prompt.

32. The system will then allow you to reenter responses to the prompts in the chosen section. Type the new information at the prompts.

33. When you are done typing responses to the prompts, the system will redisplay the patient's discharge summary, allowing you make further changes to selected sections.

34. When you are done making changes to the discharge, type NO at the "Do you want to make any changes?" prompt.

```
     Select one of the following:

          1         ADMISSION SUMMARY
          2         CAUSE OF VISIT
          3         INJURY INFO
          4         PROCEDURES
          5         EXIT ASSESSMENT
          6         DISPOSITION
          7         DISCHARGE INFO
          8         FOLLOW UP INSTRUCTIONS

Which section do you want to edit: 8  FOLLOW UP INSTRUCTIONS

~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~


*Follow up instructions: RTC PRN, INSTRUCTIONS GIVEN// appt AND INSTRUCTIONS
GIVEN
Summary of this ER data entry session for JONES, JOE =>
                    ---  ADMISSION SUMMARY  ---
Patient: JOE,JONES                        Arrival time: MAY 27,2003@14:34
Presenting Complaint: pain                Visit type: FIRST VISIT
Transferred from:
Transport to ED: PRIVATE VEHICLE/WALK IN
Ambulance ID:                             Ambulance billing #:
Ambulance company:                        Clinic type: EMERGENCY MEDICINE
Admitting provider:                       Triage nurse:
Initial triage category: 1                Seen by triage nurse at:
Seen by admitting provider at:
                    ---  CAUSE OF VISIT  ---
Related substances:                       Occupation related: NO
Occupation:                               Industry:
                    ---  INJURY INFORMATION  ---
Injury related visit: NO                  Trauma surgeon notified:
Trauma surgeon time:                      Location:
Time of injury:                           Cause of injury:
Setting:                                  Safety equipment:
What happened:
                    ---  ER PROCEDURES  ---
Procedures: NONE
                    ---  EXIT ASSESSMENT  ---
Diagnoses: pain [.9999]                   Discharge acuity: 2
                    ---  DISPOSITION  ---
Disposition: HOME                         Transfer to:
                    ---  DISCHARGE INFO  ---
Provider who signed PCC form: PROVIDER,JOE
Discharge nurse: ADAM,ADAM                Departure time: MAY 27,2003@16:08
                    ---  FOLLOW UP INSTRUCTIONS  ---
Discharge instructions: APPT AND INSTRUCTIONS GIVEN

Do you want to make any changes? No
~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~
Data entry session successfully completed...Thank you
```

Figure 5-9: Discharging an ER patient (steps 31-34)

6.0 Cancel Visit (DNA)

This option allows you to quickly cancel a patient's visit without having to go through the discharge process.

Canceling a Visit

1. Type DNA at the "Select Emergency Room System Option:" prompt.

```
   IN     Admit to Emergency Room
   TRI    Triage Nurse Update Admission Record
   BAT    Batch Mode ER Admission/Discharge
   OUT    Discharge from Emergency Room
   DNA    Cancel Visit (did not answer or left AMA)
   DOA    DOA Admission to ER
   REG    Mini-Registration of New Patients
   SCAN   Scan Patient Names or Chart Numbers
   HERE   List Patients Currently Admitted to ER
   INST   Patient Instruction Menu ...
   RPTS   Reports Menu ...
   UP     Update '.9999' ICD9 codes
   EXP    Export data Menu ...
   PAR    Table and Parameter Setup ...


Select Emergency Room System Option:    DNA  Cancel Visit (did not answer or
left AMA)
```

Figure 6-1: Canceling a visit (step 1)

2. The system will display a list of patient's currently admitted to the ER, type the number of the patient whose visit you would like to cancel at the "Select ER patient:" prompt.

3. Type the reason for the visit cancellation at the "Disposition:" prompt. Type ?? to see a list of available reasons.

4. Type the name of the provider who signed the PCC form at the "Provider who signed PCC form:" prompt.

5. Type the name of the discharging nurse at the "Discharge nurse:" prompt.

6. The system will display the patient's admission history, if you want to edit any of the fields type Yes at the "Do you want to make any changes?" prompt. If there are no changes needed, type NO and the visit will be cancelled.

```
     *****  PROCESS PATIENT WHO LEFT BEFORE VISIT WAS COMPLETED  *****


The following patients are currently admitted to the ER =>

   NAME         DOB          CHART    ADMISSION          PRESENTING COMPLAINT
-------------------------------------------------------------------------------
1) DEMO,P         AUG 01,1901  22222    MAY 27,2003@12:13  pain in neck
2) RABBITT,BUD    JAN 01,1901   123      MAY 27,2003@12:13  Heart Attack

Select ER patient: 1  DOE,JANE
  DOE,JANE                     F 08-01-1901 000351866       22222

~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~

Disposition: LEFT WITHOUT BEING DISCHARGED// ??

   Choose from:
   ADMIT TO FLOOR
   ADMIT TO ICU
   ADMIT TO OPERATING ROOM
   ADMIT TO STEPDOWN CARE UNIT
   DEATH
   HOME
   LEFT AFTER INSURANCE DENIAL
   LEFT AGAINST MEDICAL ADVICE
   LEFT WITHOUT BEING DISCHARGED
   LEFT WITHOUT BEING SEEN
   OBSERVATION
   REFERRED TO ANOTHER SERVICE
   REGISTERED IN ERROR
   TRANSFER TO ANOTHER FACILITY

Disposition: LEFT WITHOUT BEING DISCHARGED// [RET]

~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~

Provider who signed PCC form: CHASE,R

~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~

Discharge nurse: ADAM,ADAM     AA

~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~

What time did the patient depart from the ER:  NOW//   (MAY 27, 2003@12:22)
Summary of this ER data entry session for JANE DOE =>
                    ---  ADMISSION SUMMARY  ---
Patient: DOE,JANE                     Arrival time: MAY 27,2003@12:13
Presenting Complaint: pain in neck      Visit type: UNSCHEDULED REVISIT
Transferred from: ADAK BRANCH HOSPITAL  Transport to ED:
Ambulance ID:                           Ambulance billing #:
Ambulance company:                      Clinic type:
Admitting provider:                     Triage nurse:
Initial triage category:                Seen by triage nurse at:
Seen by admitting provider at:
                    ---  CAUSE OF VISIT  ---
Related substances:                     Occupation related:
Occupation:                             Industry:
                    ---  INJURY INFORMATION  ---
```

```
Injury related visit:                    Trauma surgeon notified:
Trauma surgeon time:                     Location:
Time of injury:                          Cause of injury:
Setting:                                 Safety equipment:
What happened:
                    ---  ER PROCEDURES  ---
Procedures:
                    ---  EXIT ASSESSMENT  ---
Diagnoses:                               Discharge acuity:
                    ---  DISPOSITION  ---
Disposition: LEFT WITHOUT BEING DISCHARGED
Transfer to:
                    ---  DISCHARGE INFO  ---
Provider who signed PCC form: CHASE,R    Discharge nurse: ADAM,ADAM
Departure time: MAY 27,2003@12:22
                    ---  FOLLOW UP INSTRUCTIONS  ---
Discharge instructions:


Do you want to make any changes? No// [RET]  (No)

~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~

Data entry session successfully completed...Thank you
```

Figure 6-2: Canceling a patient's visit (steps 2-6)

7.0 DOA Admissions to ER (DOA)

This option allows you to quickly enter a patient's information when they arrive to the ER as Dead on Arrival (DOA).

Using the DOA option

1. Type DOA at the "Select Emergency Room System Option:" prompt.

```
   IN     Admit to Emergency Room
   TRI    Triage Nurse Update Admission Record
   BAT    Batch Mode ER Admission/Discharge
   OUT    Discharge from Emergency Room
   DNA    Cancel Visit (did not answer or left AMA)
   DOA    DOA Admission to ER
   REG    Mini-Registration of New Patients
   SCAN   Scan Patient Names or Chart Numbers
   HERE   List Patients Currently Admitted to ER
   INST   Patient Instruction Menu ...
   RPTS   Reports Menu ...
   UP     Update '.9999' ICD9 codes
   EXP    Export data Menu ...
   PAR    Table and Parameter Setup ...


Select Emergency Room System Option:    DOA  Admission to ER
```

Figure 7-1: Using the DOA option (step 1)

2. Type the patient's name or chart number at the "Enter the patient's Name or Local Chart Number:" prompt.

3. The system will take you through the necessary admit and discharge prompts. Follow the remaining prompts as they appear on your screen. See sections 2.0 and 3.0 for more detail on the specific prompts.

4. After answering all the prompts, the system will display the patient's admission history, if you want to edit any of the fields type Yes at the "Do you want to make any changes?" prompt. If there are no changes needed, type No.

```
ER SYSTEM Ver 2.5:    DOA ADMISSION      ^ = back up     ^^ = quit
Questions preceded by a '*' are optional.  Enter '??' to see choices.

~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~

Enter the patient's NAME or LOCAL CHART NUMBER:   BUNNY,BUGGS
M 01-01-1901 000987456       65423

NO PENDING APPOINTMENTS

~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~

Date and time of admission to ER:  // NOW  (MAY 30, 2003@10:18)

~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~

Presenting complaint: DOA

~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~

     DATE OF LAST REG. UPDATE:  MAY 01, 2003

1234 MAINE LANE NE
ALBUQUERQUE, NEW MEXICO  87364
505 555 5623 (home)   (work)


~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~

Mode of transport to the ED: PRIVATE VEHICLE/WALK IN// AMBULANCE
*Ambulance number:[RET]
*Ambulance HRCN/billing number: [RET]
*Ambulance company: [RET]

~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~

Clinic type (EMERGENCY or URGENT): EMERGENCY MEDICINE// [RET]       30

~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~

*Admitting provider: [RET]

~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~

*Triage nurse: [RET]

~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~

Enter initial triage assessment from RN:  (1-5): // 5

~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~

Was this ER visit caused by an injury? NO//[RET]

~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~

Was there a positive lab screen for ALCOHOL and/or DRUG ABUSE? NO//[RET]

~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~
```

```
Was this ER visit WORK-RELATED? NO//[RET]

~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~

Enter procedure: NONE//[RET]

~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~

Enter narrative description of  the PRIMARY cause of death: old age
Enter ICD9 code: .9999// [RET]  .9999     UNCODED DIAGNOSIS    UNCODED
DIAGNOSIS
         ...OK? Yes//   (Yes) [RET]

Enter another cause of death: [RET]

~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~

Enter final acuity assessment from provider:  (1-5): // 5

~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~

Disposition: DEATH//[RET]

~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~

Provider who signed PCC form: ADAMS,FIRST     AF

~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~

What time did the patient depart from the ER:  NOW//   (MAY 30, 2003@10:20)
Summary of this ER data entry session for BUGGS BACA =>
                    ---  ADMISSION SUMMARY  ---
Patient: BUNNY,BUGGS                   Arrival time: MAY 30,2003@10:18
Presenting Complaint: DOA               Visit type: UNSCHEDULED REVISIT
Transferred from: ADAMS,FIRST           Transport to ED: AMBULANCE
Ambulance ID:                           Ambulance billing #:
Ambulance company:                      Clinic type: EMERGENCY MEDICINE
Admitting provider:                     Triage nurse:
Initial triage category: 5              Seen by triage nurse at:
Seen by admitting provider at:
                    ---  CAUSE OF VISIT  ---
Related substances:                     Occupation related: NO
Occupation:                             Industry:
                    ---  INJURY INFORMATION  ---
Injury related visit: NO                Trauma surgeon notified:
Trauma surgeon time:                    Location:
Time of injury:                         Cause of injury:
Setting:                                Safety equipment:
What happened:
                    ---  ER PROCEDURES  ---
Procedures: NONE
                    ---  EXIT ASSESSMENT  ---
Diagnoses: old age [.9999]              Discharge acuity: -1^EMERGENT
                    ---  DISPOSITION  ---
Disposition: DEATH                      Transfer to:
                    ---  DISCHARGE INFO  ---
Provider who signed PCC form: ADAM,ADAM
Discharge nurse: ADAMS,FIRST            Departure time: MAY 30,2003@10:20
                    ---  FOLLOW UP INSTRUCTIONS  ---
Discharge instructions:
```

```
Do you want to make any changes? No//   (No)
```

Figure 7-2: Using the DOA option (steps 2-4)

8.0 Mini Registration of New Patients (REG)

Use this option to register a new patient into your system. You will enter basic patient demographic information.

Adding a new patient

1. Type REG at the "Select Emergency Room System Option:" prompt.

2. Type No at the "Do you wish to scan for similar names:" prompt. If you type Yes, you will be prompted to enter the patient's name, then the system will scan for any matches.

3. Type the patient's name at the "Enter the Patient's Name:" prompt. Do not use any spaces after the comma.

4. Type Y at the "Are you adding 'patient name' as a new patient:" prompt.

```
   IN     Admit to Emergency Room
   TRI    Triage Nurse Update Admission Record
   BAT    Batch Mode ER Admission/Discharge
   OUT    Discharge from Emergency Room
   DNA    Cancel Visit (did not answer or left AMA)
   DOA    DOA Admission to ER
   REG    Mini-Registration of New Patients
   SCAN   Scan Patient Names or Chart Numbers
   HERE   List Patients Currently Admitted to ER
   INST   Patient Instruction Menu ...
   RPTS   Reports Menu ...
   UP     Update '.9999' ICD9 codes
   EXP    Export data Menu ...
   PAR    Table and Parameter Setup ...


Select Emergency Room System Option:    REG  Mini-Registration of New Patients


ADD a new patient......
Do you wish to SCAN FOR SIMILAR NAMES or CHART NUMBERS? (Y/N) ? YES// NO
Enter the NEW PATIENT'S FULL NAME.....
   (EXAMPLE:   MORGAN,JAMES PAUL,JR  (no space after commas))

Entering NEW Patient for DEMO HOSPITAL


Enter the PATIENT'S NAME: DEMO,P
   ARE YOU ADDING 'Demo, P' AS A NEW PATIENT (THE 7186TH)? No// Y  (Yes)
```

Figure 8-1: Adding a new patient (steps 1-4)

5. If you did not enter the patient's middle name, the system will prompt you to enter the patient's name, if known at the "Enter complete middle name if known, or press <return> to add as entered:" prompt. If you do not know the patient's middle name, press the Return key to skip this field.

6. Type the patient's sex at the "Patient Sex:" prompt.
7. Type the patient's date of birth at the "Patient DOB:" prompt.
8. Type the patient's Social Security Number at the "Patient SSN:" prompt.
9. The system will search for possible duplicates, if none are identified, the patient will be added.

```
Enter complete middle name if known,
     or press <return> to add as entered:
PATIENT SEX: M MALE
PATIENT DOB: 110101  (NOV 01, 1901)
PATIENT SSN: 000412365

...searching for potential duplicates

No potential duplicates have been identified.

...adding new patient
```

Figure 8-2: Adding a new patient (steps 5-9)

9.0 Scan Patient Names or Chart Numbers (SCAN)

This option gives you a chance to look up a patient before admitting them or creating a new account for the patient. There are several tricks you can use to find a patient. Try entering a partial name like 'DOE,JO' instead of 'DOE,JOHN'. Ask about other first names and married names. Try entering a date of birth in the format 9/9/99. This should narrow down the list of possible choices.

Scanning Patient Names

1. Type SCAN at the "Select Emergency Room System Option:" prompt.

2. Type the patient's name, date of birth, or chart number at the "Enter Patient Name, DOB, or Local Chart Number:" prompt.

```
   IN     Admit to Emergency Room
   TRI    Triage Nurse Update Admission Record
   BAT    Batch Mode ER Admission/Discharge
   OUT    Discharge from Emergency Room
   DNA    Cancel Visit (did not answer or left AMA)
   DOA    DOA Admission to ER
   REG    Mini-Registration of New Patients
   SCAN   Scan Patient Names or Chart Numbers
   HERE   List Patients Currently Admitted to ER
   INST   Patient Instruction Menu ...
   RPTS   Reports Menu ...
   UP     Update '.9999' ICD9 codes
   EXP    Export data Menu ...
   PAR    Table and Parameter Setup ...


Select Emergency Room System Option:    SCAN  Scan Patient Names or Chart
Numbers


There are several tricks you can use to find this patient.  Try entering a
partial name like 'DOE,JO' instead of 'DOE,JOHN'.  Ask about other first
names and married names.  Try entering a date of birth in the format 9/9/99.
This should narrow down the list of possible choices.



Enter patient NAME, DOB, or LOCAL CHART NUMBER:
```

Figure 9-1: Scanning for patients

10.0 List Patients Currently Admitted to ER (HERE)

Use this option to display a list of patient's that are currently admitted to the Emergency room.

Using the HERE option

1. Type HERE at the "Select Emergency Room System Option:" prompt.
2. The system will display a list of the patient's currently admitted to the ER.
3. If there are multiple screens of patient's, press the Return key to browse through the pages of patients.

```
   IN     Admit to Emergency Room
   TRI    Triage Nurse Update Admission Record
   BAT    Batch Mode ER Admission/Discharge
   OUT    Discharge from Emergency Room
   DNA    Cancel Visit (did not answer or left AMA)
   DOA    DOA Admission to ER
   REG    Mini-Registration of New Patients
   SCAN   Scan Patient Names or Chart Numbers
   HERE   List Patients Currently Admitted to ER
   INST   Patient Instruction Menu ...
   RPTS   Reports Menu ...
   UP     Update '.9999' ICD9 codes
   EXP    Export data Menu ...
   PAR    Table and Parameter Setup ...


Select Emergency Room System Option:    HERE  List Patients Currently Admitted
to ER



The following patients are currently admitted to the ER =>

   NAME          DOB           CHART    ADMISSION           PRESENTING COMPLAINT
------------------------------------------------------------------------------
1) Doe, John      AUG 01,1902  22222    MAY 27,2003@12:13  pain in neck
2) RABBITT,BUD    JAN 01,1901   123     MAY 27,2003@12:13  Heart Attack



Press the 'RETURN' key to go on <>
```

Figure 10-1: Displaying a list of currently admitted patients

11.0 Patient Instruction Menu (INST)

This menu option contains options that allow you to create, edit, and print Patient Instruction materials.

- To select the Patient Instruction menu, type INST at the "Select Emergency Room System Option:" prompt.

```
                  ******************************************
                  *          Emergency Room System         *
                  *          Indian Health Service         *
                  *               Version 2.5              *
                  ******************************************

                             DEMO HOSPITAL


   IN     Admit to Emergency Room
   TRI    Triage Nurse Update Admission Record
   BAT    Batch Mode ER Admission/Discharge
   OUT    Discharge from Emergency Room
   DNA    Cancel Visit (did not answer or left AMA)
   DOA    DOA Admission to ER
   REG    Mini-Registration of New Patients
   SCAN   Scan Patient Names or Chart Numbers
   HERE   List Patients Currently Admitted to ER
   INST   Patient Instruction Menu ...
   RPTS   Reports Menu ...
   UP     Update '.9999' ICD9 codes
   EXP    Export data Menu ...
   PAR    Table and Parameter Setup ...

Select Emergency Room System Option: INST  Patient Instruction Menu
```

Figure 11-1: Using the INST option

Sections 11.1 through 11.2 will provide instructions on how to use the options in the Patient Instructions menu.

```
                  ******************************************
                  *    Patient Instruction Material Menu     *
                  *          Indian Health Service           *
                  *               Version 2.5                *
                  ******************************************
                             DEMO HOSPITAL

   ADD    Add Patient Education Material
   PRT    Print Patient Education Materials

Select Patient Instruction Menu Option:
```

Figure 11-2: Displaying the INST menu options

11.1 Add Patient Education Material (ADD)

Use this option to add new or edit existing Patient Education materials that can be printed separately or during discharge

To add new Patient Education materials

1. Type ADD at the "Select Patient Instruction Menu Option:" prompt.
2. Type the name of the new topic at the "Select ER Instructions Topic:" prompt.
3. Type Y at the "Are you adding '' as a new ER Instructions?" prompt.
4. Type A (Adult) or P (Pediatric) at the "ER Instructions Category:" prompt.

```
   ADD    Add Patient Education Material
   PRT    Print Patient Education Materials

Select Patient Instruction Menu Option: ADD  Add Patient Education Material

Select ER INSTRUCTIONS TOPIC: NEW TOPIC
  Are you adding 'NEW TOPIC' as a new ER INSTRUCTIONS (the 1ST)? No// Y  (Yes)
   ER INSTRUCTIONS CATEGORY: ??

     Choose from:
       A        ADULT
       P        PEDIATRIC
   ER INSTRUCTIONS CATEGORY: A  ADULT
```

Figure 11-3: Adding new patient education materials (steps 1-4)

5. Press the Return key to accept the name of your new topic at the "Topic:" prompt.
6. Press the Return key to accept the category of your topic at the "Category:" prompt.
7. Type Y at the "Edit?" prompt to enter the description of your topic.
8. The system will take you to the RPMS word processing tool. You can either type the text in the given area, or type you information in another word processing tool like MS Word then cut and paste the text into this field. When you are done entering your text, press [PF1]-[E].

```
TOPIC: NEW TOPIC// [RET]
CATEGORY: ADULT//[RET]
Description:
  No existing text
  Edit? NO// YES

==[ WRAP ]==[ INSERT ]==========< Description >===========[ <PF1>H=Help ]====
Type the new information here




<====T=======T=======T=======T=======T=======T=======T=======T=======T>======
```

Figure 11-4: Adding new patient education materials (steps 5-8)

9. Type yes at the next "Edit?" prompt to enter your Instruction Material text.

10. The system will again take you to the RPMS word processing tool. You can either type the text in the given area, or type you information in another word processing tool like MS Word then cut and paste the text into this field. When you are done entering your text, press [PF1]-[E].

11. Your information is now stored, to enter another topic repeat this process at the next "Select ER Instructions Topic:" prompt or press the Return key at a blank "Select ER Instructions Topic:" prompt to return to the menu.

```
Instruction Material:
  No existing text
  Edit? NO// Y  YES


[ WRAP ]==[ INSERT ]========< Instruction Material >=======[ <PF1>H=Help ]===
Type more text here









<===T=======T=======T=======T=======T=======T=======T=======T=======T>======


Select ER INSTRUCTIONS TOPIC: [RET]
```

Figure 11-5: Adding new patient education materials (steps 9-11)

11.2 Print Patient Education Materials (PRT)

Use this option to print Patient Education Materials.

To Print Patient Education Materials

1. Type PRT at the "Select Patient Instruction Menu Option:" prompt.

2. Type A (Adult) or P (Pediatric) at the "Print Instructions for which Age Group:" prompt.

3. Type the name of the education topic at the "Enter Patient Education Topic:" prompt.

4. Type the name of another topic you would like to print at the "Enter another patient education topic:" prompt.

5. Press the Return key at a blank "Enter another patient education topic:" prompt when you are done entering topics for printing.

```
   ADD    Add Patient Education Material
   PRT    Print Patient Education Materials

Select Patient Instruction Menu Option: PRT  Print Patient Education Materials

     Select one of the following:

          A         ADULT
          P         PEDIATRIC

Print instructions for which age group: ADULT
Enter patient education topic: NEW NEW TOPIC       ADULT

Enter another patient education topic: [RET]
Print patient instructions on which device: HOME//  [RET]
```

Figure 11-6: Printing patient education materials

12.0 Reports Menu (RPTS)

This menu option contains options that allow you to create reports, view ER admissions from the previous day and ER log reports about specific patients.

- To select the Reports menu, type RPTS at the "Select Emergency Room System Option:" prompt.

```
                  ******************************************
                  *          Emergency Room System         *
                  *          Indian Health Service         *
                  *               Version 2.5              *
                  ******************************************

                             DEMO HOSPITAL


   IN     Admit to Emergency Room
   TRI    Triage Nurse Update Admission Record
   BAT    Batch Mode ER Admission/Discharge
   OUT    Discharge from Emergency Room
   DNA    Cancel Visit (did not answer or left AMA)
   DOA    DOA Admission to ER
   REG    Mini-Registration of New Patients
   SCAN   Scan Patient Names or Chart Numbers
   HERE   List Patients Currently Admitted to ER
   INST   Patient Instruction Menu ...
   RPTS   Reports Menu ...
   UP     Update '.9999' ICD9 codes
   EXP    Export data Menu ...
   PAR    Table and Parameter Setup ...


Select Emergency Room System Option:  RPTS   Reports Menu ...
```

Figure 12-1: Accessing the report menu

- The system will display the Reports menu (Figure 12-2:). Sections 12.1 through 12.3 will explain how to use each option.

```
                  ******************************************
                  *               Reports Menu             *
                  *          Indian Health Service         *
                  *               Version 2.5              *
                  ******************************************
                               DEMO DATABASE


   LIST   ER System Report Generator
   LOG    Print ER Log
   VIS    Display ER Log entry for a single ER visit


Select Reports Menu Option:
```

Figure 12-2: Displaying the Reports menu

12.1 ER System Report Generator (LIST)

This option provides several reports that allow you to track ER activity, statistics, and workload.

1. To select the Report Generator option, type LIST at the "Select Reports Menu Option:" prompt.

```
                  ******************************************
                  *               Reports Menu             *
                  *          Indian Health Service         *
                  *               Version 2.5              *
                  ******************************************
                              DEMO DATABASE


   LIST   ER System Report Generator
   LOG    Print ER Log
   VIS    Display ER Log entry for a single ER visit


Select Reports Menu Option:    LIST  ER System Report Generator
```

Figure 12-3: Selecting the LIST option

2. The system will display a list of report options (Figure 12-4). Sections 12.1.1 through 12.1.4 will provide more detail on how to use each of the reports.

```
                     *****  REPORT OPTIONS  *****

     Select one of the following:

          1         STANDARD ER LOG REPORT
          2         BRIEF ER LOG REPORT
          3         STATISTICAL REPORTS
          4         HOURLY WORKLOAD REPORT

Report type: 1//   STANDARD ER LOG REPORT
```

Figure 12-4: Using the list of report options

12.1.1 Standard ER Log Report (1)

A number of different reports can be generated from the Standard ER Log Report option. It generates the standard ER log report that contains all the information about the patients visit. This option is designed to provide specified sort criteria. For instance, visit data for specified Provider for the last 30 days.

Printing the standard ER log report

1. Type 1 at the "Report Type:" prompt.

2. Type the number of the display option you would like on your report at the "Your Choice:" prompt.

3. Type the starting date of the date range for your report at the "Enter Starting Date:" prompt.

4. Type the ending date of the date range for your report at the "Enter Ending Date:" prompt.

```
                    *****  REPORT OPTIONS  *****

     Select one of the following:

          1         STANDARD ER LOG REPORT
          2         BRIEF ER LOG REPORT
          3         STATISTICAL REPORTS
          4         HOURLY WORKLOAD REPORT

Report type: 1// 1  STANDARD ER LOG REPORT

                    *****  DISPLAY OPTIONS  *****

     Select one of the following:

          1         VISITS IN INVERSE ORDER OF DATES
          2         PATIENTS IN ALPHABETICAL ORDER
          3         VISITS IN CHRONOLOGICAL ORDER

Your choice: 3// 1  VISITS IN INVERSE ORDER OF DATES



                    *****  TIME FRAME  *****
Enter starting date:  T-365  (MAY 30,2002)
Enter ending date:  T  (MAY 30,2003@23:59)
```

Figure 12-5: Printing the standard ER log report (steps 1-4)

5. Type the number of the sort criteria that you would like on your report at the "Sort by:" prompt.

6. Type answers to the prompts that are specific to the sort criteria that you selected as they are displayed on your screen.

    a Some sort criteria attributes can have multiple values, so, if prompted, select the specific value you would like in your report at the "Your Choice:" prompt.

    b If prompted, select the additional sort criteria within the selected criteria as prompted by the system.

```
                    *****  SORT OPTIONS  *****

Patient attributes =>
   1)   AGE ON DAY OF VISIT                4)   ELIGIBILITY
   2)   CURRENT COMMUNITY                  5)   SEX
   3)   DOA                                6)   TRIBE

Visit attributes =>
   7)   ACUITY                             17)  INJURY CAUSE
   8)   ALCOHOL RELATED                    18)  INJURY TIME LAG
   9)   BENEFICIARY CLASS                  19)  NURSE
   10)  DIAGNOSTIC CATEGORY                20)  OCCUPATION RELATED
   11)  DISPOSITION                        21)  PHYSICIAN
   12)  EMERGENCY TRANSPORT                22)  PROCEDURE
   13)  FINAL CONDITION                    23)  REVOLVING DOOR
   14)  FIRST OR REVISIT                   24)  TOTAL VISIT DURATION
   15)  FOLLOW UP                          25)  WAITING TIME FOR THE DOCTOR
   16)  ICD9 CODE                          26)  WAITING TIME FOR TRIAGE


Sort by:  (1-26): 3  (DOA)


This attribute can have multiple values

     Select one of the following:

          1         Sort by all values of this attribute
          2         Limit output to one particular value of this attribute
          3         Display entries where attribute value is 'null'

Your choice: 1// 1  Sort by all values of this attribute

Patient attributes =>
   1)   AGE ON DAY OF VISIT                4)   ELIGIBILITY
   2)   CURRENT COMMUNITY                  5)   SEX
   3)   DOA                                6)   TRIBE

Visit attributes =>
   7)   ACUITY                             17)  INJURY CAUSE
   8)   ALCOHOL RELATED                    18)  INJURY TIME LAG
   9)   BENEFICIARY CLASS                  19)  NURSE
   10)  DIAGNOSTIC CATEGORY                20)  OCCUPATION RELATED
   11)  DISPOSITION                        21)  PHYSICIAN
   12)  EMERGENCY TRANSPORT                22)  PROCEDURE
   13)  FINAL CONDITION                    23)  REVOLVING DOOR
   14)  FIRST OR REVISIT                   24)  TOTAL VISIT DURATION
   15)  FOLLOW UP                          25)  WAITING TIME FOR THE DOCTOR
   16)  ICD9 CODE                          26)  WAITING TIME FOR TRIAGE
Within DOA sort by:  (1-26):
```

Figure 12-6: Printing the standard ER log report (steps 5-6)

7. Type any additional sort criteria at the next “Then sort by:” prompt.

8. If you are done selecting sort criteria, press the Return key at a blank “Then sort by:” prompt.

9. Type the name of a print device at the "Device:" prompt. Type HOME, if you would like your report displayed onscreen.

10. Type the size of the right margin at the "Right Margin:" prompt. Press the Return key to accept the default value of *80*.

11. The system will display or print your report.

```
Patient attributes =>
   1)   AGE ON DAY OF VISIT                4)   ELIGIBILITY
   2)   CURRENT COMMUNITY                  5)   SEX
   3)   DOA                                6)   TRIBE

Visit attributes =>
   7)   ACUITY                             17)  INJURY CAUSE
   8)   ALCOHOL RELATED                    18)  INJURY TIME LAG
   9)   BENEFICIARY CLASS                  19)  NURSE
   10)  DIAGNOSTIC CATEGORY                20)  OCCUPATION RELATED
   11)  DISPOSITION                        21)  PHYSICIAN
   12)  EMERGENCY TRANSPORT                22)  PROCEDURE
   13)  FINAL CONDITION                    23)  REVOLVING DOOR
   14)  FIRST OR REVISIT                   24)  TOTAL VISIT DURATION
   15)  FOLLOW UP                          25)  WAITING TIME FOR THE DOCTOR
   16)  ICD9 CODE                          26)  WAITING TIME FOR TRIAGE
Then sort by:  (1-26): [RET]
DEVICE: HOME    Right Margin: 80// [RET]
Please note: the following criteria were used to screen entries:

   1) AGE = "1-100"


ER REPORT                                    MAY 30,2003  11:29    PAGE 1
------------------------------------------------------------------------------


ADMISSION TIMESTAMP: MAY 27, 2003@14:34
  PATIENT: JOE,JONES                     CLINIC TYPE: EMERGENCY MEDICINE
  VISIT TYPE: FIRST VISIT                DOB: AUG 01, 1901
  LOCAL CHART NUMBER: 65441              INVERSE TIMESTAMP: 6969472.8565
  AGE ON DAY OF VISIT: 53                SEX: FEMALE
  DOB: 2148                              LOCAL CHART NUMBER: 65441
  INITIAL ACUITY: 1
  MODE OF TRANSPORT: PRIVATE VEHICLE/WALK IN
  CAUSE OF INJURY: pain                  PRESENTING COMPLAINT: pain
  OCCUPATION RELATED: NO                 INJURED: NO
PROCEDURES: NONE
DIAGNOSIS: .9999                         PROVIDER NARRATIVE: pain
  PRIMARY DIAGNOSIS: .9999               PRIMARY DX NARRATIVE: pain
  FINAL ACUITY: 2                        DISPOSITION: HOME
```

Figure 12-7: Printing the standard ER log report (steps 7-11)

12.1.2 Brief ER Log Report (2)

The Brief ER Log Report option will provide you with a condensed version of the Standard ER Log Report option. This option provides the same sort options as the Standard ER Log Report option, but contains less information on the ER visit. For

example, you can use this report to sort by community, providing the number of visits by community. Wait time reports, injury reports, and many other reports may be generated by this option.

Printing a Brief ER log report

1. Type 2 at the "Report Type:" prompt.

2. Type the number of the display option you would like on your report at the "Your Choice:" prompt.

3. Type the starting date of the date range for your report at the "Enter Starting Date:" prompt.

4. Type the ending date of the date range for your report at the "Enter Ending Date:" prompt.

```
                    *****  REPORT OPTIONS  *****

     Select one of the following:

          1         STANDARD ER LOG REPORT
          2         BRIEF ER LOG REPORT
          3         STATISTICAL REPORTS
          4         HOURLY WORKLOAD REPORT

Report type: 1// 2  BRIEF ER LOG REPORT



                    *****  DISPLAY OPTIONS  *****

     Select one of the following:

          1         VISITS IN INVERSE ORDER OF DATES
          2         PATIENTS IN ALPHABETICAL ORDER
          3         VISITS IN CHRONOLOGICAL ORDER

Your choice: 3// 1  VISITS IN INVERSE ORDER OF DATES



                    *****  TIME FRAME  *****
Enter starting date:  T-365  (MAY 30,2002)
Enter ending date:  T  (MAY 30,2003@23:59)
```

Figure 12-8: Printing a Brief ER log report (step 1-4)

5. Type the number of the sort criteria that you would like on your report at the "Sort by:" prompt.

6. Type answers to the prompts that are specific to the sort criteria that you selected as they are displayed on your screen.

a Some sort criteria attributes can have multiple values, so, if prompted, select the specific value you would like in your report at the "Your Choice:" prompt.

b If prompted, select the additional sort criteria within the selected criteria as prompted by the system.

```
                    *****  SORT OPTIONS  *****

Patient attributes =>
   1)   AGE ON DAY OF VISIT                4)   ELIGIBILITY
   2)   CURRENT COMMUNITY                  5)   SEX
   3)   DOA                                6)   TRIBE

Visit attributes =>
   7)   ACUITY                             17)  INJURY CAUSE
   8)   ALCOHOL RELATED                    18)  INJURY TIME LAG
   9)   BENEFICIARY CLASS                  19)  NURSE
   10)  DIAGNOSTIC CATEGORY                20)  OCCUPATION RELATED
   11)  DISPOSITION                        21)  PHYSICIAN
   12)  EMERGENCY TRANSPORT                22)  PROCEDURE
   13)  FINAL CONDITION                    23)  REVOLVING DOOR
   14)  FIRST OR REVISIT                   24)  TOTAL VISIT DURATION
   15)  FOLLOW UP                          25)  WAITING TIME FOR THE DOCTOR
   16)  ICD9 CODE                          26)  WAITING TIME FOR TRIAGE


Sort by:  (1-26): 4  (ELIGIBILITY)


This attribute can have multiple values

     Select one of the following:

          1         Sort by all values of this attribute
          2         Limit output to one particular value of this attribute
          3         Display entries where attribute value is 'null'

Your choice: 1// 2  Limit output to one particular value of this attribute

     Select one of the following:

          I         INELIGIBLE
          D         DIRECT ONLY
          C         CHS & DIRECT
          P         PENDING VERIFICATION

Your choice: INELIGIBLE
```

Figure 12-9: Printing a Brief ER log report (step 5-6)

7. Type any additional sort criteria at the next "Then sort by:" prompt.

8. If you are done selecting sort criteria, press the Return key at a blank "Then sort by:" prompt.

9. Type the name of a print device at the "Device:" prompt. Type HOME, if you would like your report displayed onscreen.

10. Type the size of the right margin at the "Right Margin:" prompt. Press the Return key to accept the default value of *80*.

11. The system will display or print your report.

```
Patient attributes =>
   1)   AGE ON DAY OF VISIT                4)   ELIGIBILITY
   2)   CURRENT COMMUNITY                  5)   SEX
   3)   DOA                                6)   TRIBE

Visit attributes =>
   7)   ACUITY                             17)  INJURY CAUSE
   8)   ALCOHOL RELATED                    18)  INJURY TIME LAG
   9)   BENEFICIARY CLASS                  19)  NURSE
   10)  DIAGNOSTIC CATEGORY                20)  OCCUPATION RELATED
   11)  DISPOSITION                        21)  PHYSICIAN
   12)  EMERGENCY TRANSPORT                22)  PROCEDURE
   13)  FINAL CONDITION                    23)  REVOLVING DOOR
   14)  FIRST OR REVISIT                   24)  TOTAL VISIT DURATION
   15)  FOLLOW UP                          25)  WAITING TIME FOR THE DOCTOR
   16)  ICD9 CODE                          26)  WAITING TIME FOR TRIAGE
Then sort by:  (1-26): [RET]
DEVICE: [RET]    Right Margin: 80//[RET]
Please note: the following criteria were used to screen entries:

   1) ELIGIBILITY = "INELIGIBLE"


ER REPORT                                    MAY 30,2003  11:54    PAGE 1
                                                            PRIMARY DX
DATE     TIME     PATIENT        CHART  DOB      PHYSICIAN    NARRATIVE
-------------------------------------------------------------------------------




          *** NO RECORDS TO PRINT ***
Press the 'RETURN' key to go on...
```

Figure 12-10: Printing a Brief ER log report (step 7-11)

12.1.3 Statistical Reports (3)

The Statistical Reports option is used to provide you with statistics for a given sort value. These reports provide the same 26 sort options as the other reports in the LIST option. For instance, if you sort by Provider wait time, you will be provided with an overview of the length of time patients have to wait to see the Provider. This report could be reviewed for staffing issues.

Printing Statistical Reports

1. Type 3 at the "Report Type:" prompt.

2. Type the starting date of the date range for your report at the "Enter Starting Date:" prompt.

3. Type the ending date of the date range for your report at the "Enter Ending Date:" prompt.

```
                  ******************************************
                  *               Reports Menu             *
                  *          Indian Health Service         *
                  *               Version 2.5              *
                  ******************************************
                              DEMO DATABASE


   LIST   ER System Report Generator
   LOG    Print ER Log
   VIS    Display ER Log entry for a single ER visit


Select Emergency Room System Option:     LIST  ER System Report Generator

                    *****  REPORT OPTIONS  *****

     Select one of the following:

          1         STANDARD ER LOG REPORT
          2         BRIEF ER LOG REPORT
          3         STATISTICAL REPORTS
          4         HOURLY WORKLOAD REPORT

Report type: 1// 4  STATISTICAL REPORTS


                    *****  TIME FRAME  *****
Enter starting date:  T-365  (JUN 2,2002)
Enter ending date:  T  (JUN 2,2003@23:59)
```

Figure 12-11: Printing Statistical Reports (steps 1-3)

4. Type the number of the sort criteria that you would like on your report at the "Sort by:" prompt.

5. Type answers to the prompts that are specific to the sort criteria that you selected as they are displayed on your screen.

    a. Some sort criteria attributes can have multiple values, so, if prompted, select the specific value you would like in your report at the "Your Choice:" prompt.

    b. If prompted, select the additional sort criteria within the selected criteria as prompted by the system.

```
                    *****  SORT OPTIONS  *****

Patient attributes =>
   1)   AGE ON DAY OF VISIT                4)   ELIGIBILITY
   2)   CURRENT COMMUNITY                  5)   SEX
   3)   DOA                                6)   TRIBE

Visit attributes =>
   7)   ACUITY                             17)  INJURY CAUSE
   8)   ALCOHOL RELATED                    18)  INJURY TIME LAG
   9)   BENEFICIARY CLASS                  19)  NURSE
   10)  DIAGNOSTIC CATEGORY                20)  OCCUPATION RELATED
   11)  DISPOSITION                        21)  PHYSICIAN
   12)  EMERGENCY TRANSPORT                22)  PROCEDURE
   13)  FINAL CONDITION                    23)  REVOLVING DOOR
   14)  FIRST OR REVISIT                   24)  TOTAL VISIT DURATION
   15)  FOLLOW UP                          25)  WAITING TIME FOR THE DOCTOR
   16)  ICD9 CODE                          26)  WAITING TIME FOR TRIAGE


Sort by:  (1-26): 6  (TRIBE)


This attribute can have multiple values

     Select one of the following:

          1         Do statistical analysis on this attribute now
          2         Analyze only those entries with one particular value
          3         Analyze only those entries where attribute value is 'null'

Your choice: 1// 2  Analyze only those entries with one particular value
Select TRIBE: NAVAJO TRIBE OF AZ, NM AND UT       084

Patient attributes =>
   1)   AGE ON DAY OF VISIT                4)   ELIGIBILITY
   2)   CURRENT COMMUNITY                  5)   SEX
   3)   DOA                                6)   TRIBE

Visit attributes =>
   7)   ACUITY                             17)  INJURY CAUSE
   8)   ALCOHOL RELATED                    18)  INJURY TIME LAG
   9)   BENEFICIARY CLASS                  19)  NURSE
   10)  DIAGNOSTIC CATEGORY                20)  OCCUPATION RELATED
   11)  DISPOSITION                        21)  PHYSICIAN
   12)  EMERGENCY TRANSPORT                22)  PROCEDURE
   13)  FINAL CONDITION                    23)  REVOLVING DOOR
   14)  FIRST OR REVISIT                   24)  TOTAL VISIT DURATION
   15)  FOLLOW UP                          25)  WAITING TIME FOR THE DOCTOR
   16)  ICD9 CODE                          26)  WAITING TIME FOR TRIAGE
Then sort by:  (1-26): 7  (ACUITY)

     Select one of the following:

          1         Do statistical analysis of patient acuities now
          2         Limit analysis to patients in a certain acuity range

Your choice: 1// 2  Limit analysis to patients in a certain acuity range
Start with what acuity:  (1-5): 1
Go to what acuity:  (1-5): 2
```

Figure 12-12: Printing Statistical Reports (steps 4-5)

6. Type any additional sort criteria at the next "Then sort by:" prompt.

7. If you are done selecting sort criteria, press the Return key at a blank "Then sort by:" prompt.

8. Type the name of a print device at the "Device:" prompt. Type HOME, if you would like your report displayed onscreen.

9. Type the size of the right margin at the "Right Margin:" prompt. Press the Return key to accept the default value of *80*.

10. The system will display or print your report.

```
Patient attributes =>
   1)   AGE ON DAY OF VISIT                4)   ELIGIBILITY
   2)   CURRENT COMMUNITY                  5)   SEX
   3)   DOA                                6)   TRIBE

Visit attributes =>
   7)   ACUITY                             17)  INJURY CAUSE
   8)   ALCOHOL RELATED                    18)  INJURY TIME LAG
   9)   BENEFICIARY CLASS                  19)  NURSE
   10)  DIAGNOSTIC CATEGORY                20)  OCCUPATION RELATED
   11)  DISPOSITION                        21)  PHYSICIAN
   12)  EMERGENCY TRANSPORT                22)  PROCEDURE
   13)  FINAL CONDITION                    23)  REVOLVING DOOR
   14)  FIRST OR REVISIT                   24)  TOTAL VISIT DURATION
   15)  FOLLOW UP                          25)  WAITING TIME FOR THE DOCTOR
   16)  ICD9 CODE                          26)  WAITING TIME FOR TRIAGE
Then sort by:  (1-26): [RET]
DEVICE: [RET]    Right Margin: 80//[RET]
Please note: the following criteria were used to screen entries:

   1) FINAL ACUITY = "1-2"
   2) TRIBE = "NAVAJO TRIBE OF AZ, NM AND UT"
```

Figure 12-13: Printing Statistical Reports (steps 6-10)

12.1.4 Hourly Workload Report (4)

This report is used to review the workload of the Providers and Triage. The report provides timeframes and can be used to sort by specific Provides. Minimum, maximum, and average values are reported for the time frames.

Printing the Hourly Workload Report

1. Type 4 at the "Report Type:" prompt.

2. Type the starting date of the date range for your report at the "Enter Starting Date:" prompt.

3. Type the ending date of the date range for your report at the "Enter Ending Date:" prompt.

```
                  ******************************************
                  *               Reports Menu             *
                  *          Indian Health Service         *
                  *               Version 2.5              *
                  ******************************************
                              DEMO DATABASE


   LIST   ER System Report Generator
   LOG    Print ER Log
   VIS    Display ER Log entry for a single ER visit


Select Emergency Room System Option:    LIST  ER System Report Generator



                    *****  REPORT OPTIONS  *****

     Select one of the following:

          1         STANDARD ER LOG REPORT
          2         BRIEF ER LOG REPORT
          3         STATISTICAL REPORTS
          4         HOURLY WORKLOAD REPORT

Report type: 1// 4  HOURLY WORKLOAD REPORT



                    *****  TIME FRAME  *****
Enter starting date:  T-30  (MAY 3,2003)
Enter ending date:  T  (JUN 2,2003@23:59)
```

Figure 12-14: Printing the Hourly Workload Report (steps 1-3)

4. Type 1, 2, or 3 at the "Sort option:" prompt. If you select 1 (Sort by a Specific Provider)

```
     Select one of the following:

          1         SORT BY A SPECIFIC PROVIDER
          2         SORT BY ALL PROVIDERS
          3         DO NOT SORT BY PROVIDER

Sort option: 3// 1  SORT BY A SPECIFIC PROVIDER
Enter PROVIDER NAME: PROVIDER  PROVIDER,JOE       JAC          Physician


Some of the times recorded in the database may be invalid; i.e., negative or
excessively long intervals.
Want to FILTER out data which is likely to be invalid? No// Y  (Yes)


Print HOURLY WORKLOAD TOTALS on which device: HOME// [RET]


                    *****  HOURLY WORKLOAD REPORT  *****

PROVIDER,JOE
MAY 27,2003
VISIT TIME  # PTS  MINS TO TRIAGER   MINS TO PROVIDER  AGE<14  ETOH  INJURY
                   MIN   MAX   AVE   MIN   MAX   AVE
----------  -----  ----  ----  ----  ----  ----  ----  ------  ----  ------
0000-0059       0
0100-0159       0
0200-0259       0
0300-0359       0
0400-0459       0
0500-0559       0
0600-0659       0
0700-0759       0
0800-0859       0
0900-0959       0
1000-1059       0
1100-1159       1    62    62    62   122   122   122       0     0       0

TOTALS          2                                           0     0       0
AVERAGES             62    62    62   122   122   122
```

Figure 12-15: Printing the Hourly Workload Report

12.2 Print ER Log (LOG)

Use this option to print a list of ER patients. This report is a default date of the previous day's admissions to the ER.

Printing the ER log

1. Type LOG at the "Select Reports Menu Option:" prompt.

2. Type the name of a print device at the "Device:" prompt. To display the log onscreen, type HOME.

3. Type the size of the right margin at the "Right Margin:" prompt. To accept the default value of 80, press the Return key.

```
                  ******************************************
                  *               Reports Menu             *
                  *          Indian Health Service         *
                  *               Version 2.5              *
                  ******************************************
                                DEMO DATABASE


   LIST   ER System Report Generator
   LOG    Print ER Log
   VIS    Display ER Log entry for a single ER visit

Select Reports Menu Option:    LOG  Print ER Log

DEVICE: HOME    Right Margin: 80// [RET]
ER REPORT                                    MAY 27,2003  12:26    PAGE 1
                                                            PRIMARY DX
DATE     TIME     PATIENT        CHART  DOB      PHYSICIAN    NARRATIVE
------------------------------------------------------------------------------

05/27/03 12:18 PM BUNNY,JULIE                     JONES,C      heart attack
05/27/03 12:13 PM DOE,JANE 22222  08/15/80 CHASE,R
05/27/03 11:58 AM DOE,JOHN   33574  06/12/63 CHAPEK,J     car accident

Press the 'RETURN' key to go on...
```

Figure 12-16: Printing the ER log

12.3 Display ER Log entry for a single ER visit (VIS)

This option allows you display the ER log for a particular patient and visit.

Displaying a single ER visit

1. Type VIS at the "Select Reports Menu Option:" prompt.

2. Type the patient's name, DOB, or chart number at the "Enter name, DOB or chart number" prompt.

3. If the patient has more than one visit on record, the system will display all visits. Type the number of the visit you are interested in at the "CHOOSE 1-?:" prompt.

4. The system will then display the patient's ER log. Press the Return key to scroll through the pages.

```
                  ******************************************
                  *                Reports Menu            *
                  *          Indian Health Service         *
                  *                Version 2.5             *
                  ******************************************
                               DEMO DATABASE


   LIST   ER System Report Generator
   LOG    Print ER Log
   VIS    Display ER Log entry for a single ER visit

Select Reports Menu Option:    VIS  Display ER Log entry for a single ER visit

Enter name, DOB or chart number:  DOE,JOHN
                         M 06-01-1901 000748159       33574

     1   10195  5-27-2003@11:58:00
     2   10195  5-27-2003@14:30:00
CHOOSE 1-2: 1                            5-27-2003@11:58:00

DEVICE: HOME    Right Margin: 80// [RET]

ER VISIT LIST                                    MAY 27,2003  12:37    PAGE 1
------------------------------------------------------------------------------

        NUMBER: 1

ADMISSION TIMESTAMP: MAY 27, 2003@11:58
  PATIENT: DOE,JOHN                     CLINIC TYPE: EMERGENCY MEDICINE
  VISIT TYPE: UNSCHEDULED REVISIT        ADMITTING PROVIDER: PROVIDER,JOE
  TRIAGE NURSE: ADAM,ADAM                DOB: JUN 01, 1901
  LOCAL CHART NUMBER: 33574              INVERSE TIMESTAMP: 6969472.8841
  AGE ON DAY OF VISIT: 39                SEX: MALE
  DOB: 2148                              LOCAL CHART NUMBER: 33574
  TRAUMA SURGEON NOTIFIED: NO            INITIAL ACUITY: 1
  MODE OF TRANSPORT: PRIVATE VEHICLE/WALK IN
  CAUSE OF INJURY: heart attack          PRESENTING COMPLAINT: heart attack
  OCCUPATION RELATED: YES                OCCUPATION: occ
  INJURED: NO                            TOWN OF INJURY: dulce
PROCEDURES: BLOOD TRANSFUSION
DIAGNOSIS: 234.0                         PROVIDER NARRATIVE: car accident
  PRIMARY DIAGNOSIS: 234.0               PRIMARY DX NARRATIVE: car accident
  FINAL ACUITY: 3                        DISPOSITION: HOME
  DEPARTURE TIME: MAY 27, 2003@16:00     DISCHARGE PROVIDER: PROVIDER,JOE
  DISCHARGE NURSE: ADAM,ADAM

ER VISIT LIST                                    MAY 27, 2003@12:37    PAGE 2
------------------------------------------------------------------------------

  DISCHARGE INSTRUCTIONS: RTC PRN, INSTRUCTIONS GIVEN

  ALCOHOL RELATED VISIT: NO              DRUG RELATED VISIT: NO
  SUBSTANCE RELATED VISIT: NO            ADMITTING PROV TIME: MAY 27,
2003@14:00
  TRIAGE NURSE TIME: MAY 27, 2003@13:00
  WAITING TIME FOR PROV: 122             WAITING TIME FOR TRIAGE: 62
  TOTAL VISIT DURATION: 242              DATA EXPORT STATUS: EXPORT PENDING

Enter RETURN to continue or '^' to exit:
```

Figure 12-17: Displaying a single visit

13.0 Update '.9999' ICD9 codes (UP)

This option enables coders to locate all '.9999' codes in the ER VISIT file and update them to a more definitive code. Updates produce a new V POV entry and change the value of the ICD9 codes in the ER VISIT file.

To update .9999 ICD9 Codes

1. Type UP at the "Select Emergency Room System Option:" prompt.

2. The system will bring up the first code that needs to be updated and display the provider narrative that was entered at the time of discharge.

3. You are able to scroll through the uncoded entries by pressing the Return key at a blank "Select ICD Diagnosis Code Number:" prompt following a given provider narrative.

4. When you reach the code that you would like to update, type either the correct ICD9 code or a keyword at the "Select ICD Diagnosis Code Number:" prompt. If you type a keyword, the system will display a list of ICD9 codes. Type the corresponding number at "Select #-#:" prompt.

```
                  ******************************************
                  *          Emergency Room System         *
                  *          Indian Health Service         *
                  *               Version 2.5              *
                  ******************************************

                            DEMO HOSPITAL


   IN     Admit to Emergency Room
   TRI    Triage Nurse Update Admission Record
   BAT    Batch Mode ER Admission/Discharge
   OUT    Discharge from Emergency Room
   DNA    Cancel Visit (did not answer or left AMA)
   DOA    DOA Admission to ER
   REG    Mini-Registration of New Patients
   SCAN   Scan Patient Names or Chart Numbers
   HERE   List Patients Currently Admitted to ER
   INST   Patient Instruction Menu ...
   RPTS   Reports Menu ...
   UP     Update '.9999' ICD9 codes
   EXP    Export data Menu ...
   PAR    Table and Parameter Setup ...

Select Emergency Room System Option:    UP  Update '.9999' ICD9 codes

                    *****  UPDATE ".9999" CODES  *****

Provider narrative: "hear"
Select ICD DIAGNOSIS CODE NUMBER: [RET]

Provider narrative: "pain"
Select ICD DIAGNOSIS CODE NUMBER: PAIN
( PAIN/PAINFUL/PAINLESS/PAINS/PAINT/PAINTS )
.....................................................................

The following matches were found:

   1: 304.61 (DRUG DEPEND NEC-CONTIN)
       OTHER SPECIFIED DRUG DEPENDENCE, CONTINUOUS USE

   2: 304.62 (DRUG DEPEND NEC-EPISODIC)
       OTHER SPECIFIED DRUG DEPENDENCE, EPISODIC USE

   3: 304.63 (DRUG DEPEND NEC-IN REM)
       OTHER SPECIFIED DRUG DEPENDENCE, IN REMISSION

   4: 350.2 (ATYPICAL FACE PAIN)
       ATYPICAL FACE PAIN

   5: 379.91 (PAIN IN OR AROUND EYE)
       PAIN IN OR AROUND EYE

Select 1-85: 4
```

Figure 13-1: Updating the ICD9 codes

14.0 Export Data Menu (EXP)

This menu option is used for exporting files, either in an access format or flat file. Parameter file needs to be updated before files can be created.

- To access the EXP menu, type EXP at the "Select Emergency Room System Option:" prompt. The menu options will be displayed. Sections 14.1 and 14.2 explain how to use the EXPA and EXPE options.

```
                  ******************************************
                  *          Emergency Room System         *
                  *          Indian Health Service         *
                  *               Version 2.5              *
                  ******************************************

                             DEMO HOSPITAL


   IN     Admit to Emergency Room
   TRI    Triage Nurse Update Admission Record
   BAT    Batch Mode ER Admission/Discharge
   OUT    Discharge from Emergency Room
   DNA    Cancel Visit (did not answer or left AMA)
   DOA    DOA Admission to ER
   REG    Mini-Registration of New Patients
   SCAN   Scan Patient Names or Chart Numbers
   HERE   List Patients Currently Admitted to ER
   INST   Patient Instruction Menu ...
   RPTS   Reports Menu ...
   UP     Update '.9999' ICD9 codes
   EXP    Export data Menu ...
   PAR    Table and Parameter Setup ...

Select Emergency Room System Option: EXP

                  ******************************************
                  *             Export Data Menu           *
                  *          Indian Health Service         *
                  *               Version 2.5              *
                  ******************************************

                             DEMO HOSPITAL


   EXPA   Export data to ACCESS File Format
   EXPE   Export data to file

Select Export data Menu Option:
```

Figure 14-1: Using the Export menu option

14.1 Export Data to Access File Format (EXPA)

This option will allow you to export ER data to a Microsoft Access file format. You need to set up the file path and file in the Facility Parameter Setup option (section 15.3).

Exporting data to an Access file format

1. Type EXPA at the "Export Data Menu Option:" prompt.

2. The system will then export the file and path that you set up using the Facility Parameter Setup option (section 15.3).

3. The system will give an error message if the files are not setup correctly. If the export files are created the system will display `Export files successfully created.`

4. Archiving is not automatically completed, you will need to move the previous files before exporting the data.

```
                  ******************************************
                  *             Export Data Menu           *
                  *          Indian Health Service         *
                  *               Version 2.5              *
                  ******************************************

                              DEMO DATABASE


   EXPA   Export data to ACCESS File Format
   EXPE   Export data to file

Select Export data Menu Option: EXPA  Export data to ACCESS File Format

Export files successfully created!
They are located in 'C:\PUB\'


<>
```

Figure 14-2: Exporting data to an Access file format

14.2 Export Data to File (EXPE)

This option will allow you to export data to a particular file.

Exporting data to file

1. Type EXPE at the "Select Export Data Menu Option:" prompt.

2. The system will then export the file and path that you set up using the Facility Parameter Setup option (section 15.3).

3. The system will give an error message if the files are not setup correctly (Figure 14-4). If the export files are created the system will display `Export files successfully created` (Figure 14-3).

4. Archiving is not automatically completed, you will need to move the previous files before exporting the data.

```
                  ******************************************
                  *             Export Data Menu           *
                  *          Indian Health Service         *
                  *               Version 2.5              *
                  ******************************************

                              DEMO DATABASE


   EXPA   Export data to ACCESS File Format
   EXPE   Export data to file

Select Export data Menu Option:  EXPE Export data to file


Export files successfully created!
They are located in 'C:\PUB\'
```

Figure 14-3: Using the EXPE option

```
                  ******************************************
                  *             Export Data Menu           *
                  *          Indian Health Service         *
                  *               Version 2.5              *
                  ******************************************

                              DEMO DATABASE


   EXPA   Export data to ACCESS File Format
   EXPE   Export data to file

Select Export data Menu Option: EXPE  Export data to file


Export failed!!!  No text files have been created
THESE OLD FILES MUST BE EXPORTED AND REMOVED FROM THE EXPORT DIRECTORY:
   PATCAUS.TXT
   PATDIAG.TXT
   PATIENT.TXT
   PATPAYO.TXT
```

Figure 14-4: Error message for EXPE

15.0 Table and Parameter Setup (PAR)

This option is used to setup the local parameters for the local facility and tables for the ER files, such as local ER facilities, procedures, and disposition.

- To access the Table and Parameter Setup menu, type PAR at the "Select Emergency Room System Option:" prompt.

```
                  ******************************************
                  *          Emergency Room System         *
                  *          Indian Health Service         *
                  *               Version 2.5              *
                  ******************************************

                              DEMO HOSPITAL

   IN     Admit to Emergency Room
   TRI    Triage Nurse Update Admission Record
   BAT    Batch Mode ER Admission/Discharge
   OUT    Discharge from Emergency Room
   DNA    Cancel Visit (did not answer or left AMA)
   DOA    DOA Admission to ER
   REG    Mini-Registration of New Patients
   SCAN   Scan Patient Names or Chart Numbers
   HERE   List Patients Currently Admitted to ER
   INST   Patient Instruction Menu ...
   RPTS   Reports Menu ...
   UP     Update '.9999' ICD9 codes
   EXP    Export data Menu ...
   PAR    Table and Parameter Setup ...

Select Emergency Room System Option: PAR    Table and Parameter Setup
```

Figure 15-1: Accessing the PAR option

15.1 Add Local ER Facilities (LOC)

This option is used to add local facility to the ER Local Facility file. These entries are used in transferred from and to prompts during admission and discharge.

1. To access the Add Local ER Facilities menu, type LOC at the "Select Table and Parameter Setup Option:" prompt.

2. Type the name of the Local ER Facility that you would edit/add at the "Select ER LOCAL FACILITY NAME:" prompt. If there are similar matches, the system will ask you to select your facility from a list, and then confirm that selection by typing Y at the "OK?" prompt.

3. You will next be prompted for the UID for the Local ER. Enter information at the "UID:" prompt or "return" to continue.

```
                  ******************************************
                  *           Facility Setup Menu          *
                  *          Indian Health Service         *
                  *               Version 2.5              *
                  ******************************************
                               DEMO DATABASE


   LOC    Add Local ER Facilities
   OPT    ER Options Transportation-Disposition-Procedures
   SET    Facility Parameter setup

Select Table and Parameter Setup Option: LOC    Add Local ER Facilities

Select ER LOCAL FACILITY NAME: DEMO Hospital ER
  Are you adding 'DEMO Hospital ER' as
    a new ER LOCAL FACILITY (the 3RD)? No// Y  (Yes)
NAME: DEMO Hospital ER//
UID:

Select ER LOCAL FACILITY NAME:
```

Figure 15-2: Using the PAR option

15.2 ER Options Transportation-Disposition-Procedures (OPT)

This option is used to add information to the table that stores the different categories such as transportation, disposition and procedure information. There are 27 types of categories. These entries are used in different prompts through out the admission and discharge functions.

1. To access the ER Options Transportation-Disposition-Procedures option, type OPT at the "Select Table and Parameter Setup Option:" prompt.

```
                  ******************************************
                  *           Facility Setup Menu          *
                  *          Indian Health Service         *
                  *               Version 2.5              *
                  ******************************************
                               DEMO DATABASE


   LOC    Add Local ER Facilities
   OPT    ER Options Transportation-Disposition-Procedures
   SET    Facility Parameter setup

Select Table and Parameter Setup Option: OPT    ER Options Transportation-
Disposition-Procedures
```

Figure 15-3: Using the OPT option (step 1)

2. Type the entry you would like to add at the "Select ER OPTIONS NAME:" prompt.

3. Type the category the ER option is listed as for the example procedure at the "TYPE:" prompt. You will then be able to use this entry in the procedure field during admission/discharge.

```
Select ER OPTIONS NAME: BLOOD TRANSFUSION
NAME: BLOOD TRANSFUSION// [RET]
TYPE: ER PROCEDURES// ?
 Answer with ER CATEGORIES NAME
 Do you want the entire 27-Entry ER CATEGORIES List? Y  (Yes)
   Choose from:
   ADMISSION SUMMARY
   AMBULANCE COMPANY
   CAUSE OF INJURY
   CAUSE OF VISIT
   CLINIC TYPE
   DIAGNOSES
   DISCHARGE INFO
   DISPOSITION
   ER PROCEDURES
   EXIT ASSESSMENT
   FOLLOW UP INSTRUCTIONS
   INJURY INFORMATION
   MODE OF TRANSPORT
   MOTOR VEHICLE COLLISION INFO
   NURSE
   PATIENT INSTRUCTIONS (ADULT)
   PATIENT INSTRUCTIONS (PEDIATRI
   PREDISPOSING FACTORS
   RED FLAGS
   REFERRAL FACILITIES
   RESPONSIBLE PARTY INFO
   SAFETY EQUIPMENT
   SCENE OF INJURY
   SUBSTANCES
   TRANSFER DETAILS
   TRIAGE CATEGORY
   VISIT TYPE

TYPE: ER PROCEDURES//
```

Figure 15-4: Using the OPT option (steps 2-3)

4. Press the Return key at the “Brief Form:” prompt.

5. Type the HER value or press the Return key to accept the default entry at the “Her Value:” prompt.

6. Type the ancillary services at the “Ancillary Services:” prompt. Type ?? to see a list of available options.

7. Type a mnemonic at the “Mnemonic:” prompt.

8. Type the ICD9 code at the “ICD9 Code:” prompt.

```
BRIEF FORM:
HER VALUE: 99.03//
ANCILLARY SERVICES: INTRAVENOUS// ??

     Choose from:
       1        CARDIOVASCULAR
       2        INTRAVENOUS
       3        LABORATORY
       4        RADIOLOGY
       5        RESPIRATORY
       6        OTHER
ANCILLARY SERVICES: INTRAVENOUS//
   SAFE
MNEMONIC:
MAP TO PLACE OF ACCIDENT:
ICD9 CODE:
```

Figure 15-5: Using the OPT option (steps 4-8)

15.3 Facility Parameter Setup (SET)

Use this menu option to edit the parameter setup for an ER facility.

To use the Facility Parameter setup option

1. Type SET at the "Select Table and Parameter Setup Option:" prompt.

2. Type the name of the facility that you would edit/establish at the "Select ER Preferences Location:" prompt. If there are similar matches, the system will ask you to select your facility from a list, and then confirm that selection by typing Y at the "OK?" prompt.

```
                  ******************************************
                  *           Facility Setup Menu          *
                  *          Indian Health Service         *
                  *               Version 2.5              *
                  ******************************************
                               DEMO DATABASE


   LOC    Add Local ER Facilities
   OPT    ER Options Transportation-Disposition-Procedures
   SET    Facility Parameter setup

Select Table and Parameter Setup Option: SET    Facility Parameter setup


Select ER PREFERENCES LOCATION: SSM TRIBAL HEALTH CENTER       BEMIDJI NON-IHS
     EASTERN MICHIGAN       10
         ...OK? Yes// [RET]  (Yes)
```

Figure 15-6: Using the SET option (steps 1-2)

3. Type the location or press the Return key to accept the current entry at the "Location:" prompt.

4. Type the HFS number or press the Return key to accept the current entry at the "HFS Number:" prompt.

5. Type the HFS String at the "Open HFS String:" prompt. If there is currently an entry, you can edit it by using the RPMS replace convention.

6. Type the HFS Status at the "HFS Status:" prompt. If there is currently an entry, you can edit it by using the RPMS replace convention.

7. Type the export file name that you will use for the export option or press the Return key to accept the current entry at the "Export File Name:" prompt.

```
LOCATION: SSM TRIBAL HEALTH CENTER// [RET]
HFS NUMBER: 51//[RET]
OPEN HFS STRING: O AMERDEV:(AMERFNAM:"W"):5  Replace [RET]
HFS STATUS: O AMERDEV:(AMERFNAM):5  Replace [RET]
EXPORT FILE NAME: d:\db4\mainudi1.txt//[RET]
```

Figure 15-7: Using the SET option (steps 3-7)

8. Type the HFS Close or press the Return key to accept the current entry at the "HFS Close:" prompt.

9. Type the HFS Use or press the Return key to accept the current entry at the "HFS Use:" prompt.

10. Type the Walk-in clinic number or press the Return key to accept the current entry at the "Walk-In Clinic:" prompt.

11. Type the Label Printer Name at the "Label Printer Name:" prompt.

12. Type Y or N at the "Queue Labels:" prompt or press the Return key to bypass this field.

13. Type the name of the chart printer at the "Chart Printer Name:" prompt or press the Return key to bypass this field.

14. Type the path to the export directory at the "Path to Export Directory:" prompt or press the Return key to accept the current entry.

15. Type the name of another ER Preferences Location at the "Select ER Preferences Location:" prompt or press the Return key to exit.

```
HFS CLOSE: C AMERDEV//[RET]
HFS USE: U AMERDEV//[RET]
WALK-IN CLINIC: 29//[RET]
LABEL PRINTER NAME: T12//[RET]
QUEUE LABELS: [RET]
CHART PRINTER NAME: [RET]
PATH TO EXPORT DIRECTORY: C:\EDIMPORT\//[RET]

Select ER PREFERENCES LOCATION: [RET]
```

Figure 15-8: Using the SET option (steps 8-15)

16.0 Glossary

Term	Definition
Default Response	Many of the prompts in the A/R program contain responses that can be activated simply by pressing the Return key . For example: "Do you really want to quit? No//." Pressing the Return key tells the system you do not want to quit. "No//" is considered the default response.
Device	The name of the printer you want the system to use when printing information. Home means the computer screen.
Discharge	To release a patient from care
DOB	Date of Birth
DOS	Date Of Service
Enter Key	Used interchangeably with the Return key. Press the Enter key to show the end of an entry such as a number or a word. Press the Enter key each time you respond to a computer prompt. If you want to return to the previous screen, simply press the Enter key without entering a response. This will take you back to the previous menu screen. The Enter key on some keyboards are shown as the Return Key. Whenever you see [ENT] or the Enter key, press the Enter or Return Key.
Export	To format data so it can be used by another application.
Fields	Fields are a collection of related information that comprises a record. Fields on a display screen function like blanks on a form. For each field, you will find a prompt requesting specific types of data. There are nine basic field types in RPMS programs, and each collects a specific type of information.
File	A set of related records or entries treated as a single unit.
FileMan	The database management system for RPMS.
Free Text Field	This field type will accept numbers, letter, and most of the symbols on the keyboard. There may be restrictions on the number of characters you are allowed to enter.
Full Screen Editor	A word processing system used by RPMS. In many ways, the Full Screen Text Editor works just like a traditional word processor. The lines wrap automatically, the up, down, right, and left arrows move the cursor around the screen, and a combination of upper and lower case letters can be used.
Global	In MUMPS, global refers to a variable stored on disk (global variable) or the array to which the global variable may belong

Term	Definition
	(global array).
I/T/U	Abbreviation referring to all IHS direct, tribal, and urban facilities. Using the abbreviation I/T/U generally means that all components of the Indian health care system are being referred to.
ICD Codes	One of several code sets used by the healthcare industry to standardize data. The International Classification of Disease is an international diagnostic coding scheme. In addition to diseases, ICD also includes several families of terms for medical-specialty diagnoses, health status, disablements, procedure and reasons for contact with healthcare providers. IHS currently uses ICD-9 for coding. GPRA+ searches for ICD and other codes as specified in the logic definition to determine if a patient meets a denominator or numerator definition.
INDEX (%INDEX)	A Kernel utility used to verify routines and other MUMPS code associated with a package. Checking is done according to current ANSI MUMPS standards and RPMS programming standards. This tool can be invoked through an option or from direct mode (>D ^%INDEX).
Init	Initialization of an application package. The initialization step in the installation process builds files from a set of routines (the init routines). Init is a shortened form of initialization.
Interfaces	A boundary where two systems can communicate.
Kernel	The set of MUMPS software utilities that function as an intermediary between the host operating system and application packages, such as Laboratory and Pharmacy. The Kernel provides a standard and consistent user and programmer interface between application packages and the underlying MUMPS implementation. These utilities provide the foundation for RPMS.
Line Editor	A word-processing editor that allows to you edit text line by line.
Logic	The detailed definition, including specific RPMS fields and codes, of how the software defines a denominator or numerator.
MailMan	Short for Mail Manager, MailMan is a VA-based utility that facilitates messaging for a number of RPMS packages.
Mandatory	Required. A mandatory field is a field that must be completed before the system will allow you to continue.
Menu	A list of choices for computing activity. A menu is a type of option designed to identify a series of items (other options) for presentation to the user for selection. When displayed, menu-type options are preceded by the word “Select” and followed by the word “option” as in Select Menu Management option: (the

Term	Definition
	menu's select prompt).
Mg/dl	Milligram/deciliter, units of measurement
Mnemonic	A short cut that designated to access a particular party, name, or facility.
Mode of Transportation	The method that the patient arrived at the facility (i.e. Car, taxi, walked)
Namespace	A unique set of 2 to 4 alpha characters that are assigned by the database administrator to a software application.
Narrative Description	A detailed description given using words rather than codes.
No-show	A person who makes an appointment but does not show up for or cancel the appointment.
Option	An entry in the Option file. As an item on a menu, an option provides an opportunity for users to select it, thereby invoking the associated computing activity. Options may also be scheduled to run in the background, non-interactively, by TaskMan.
Outpatient Treatment	Treatment that occurs within a medical facility that does not involve an overnight stay.
Party	A person or a group
Prompt	A field displayed onscreen indicating that the system is waiting for input. Once the computer displays a prompt, it waits for you to enter some specific information.
Provider	One who provides direct medical care to a patient (i.e. physician, nurse, physician's assistant).
Provider Codes	Codes that are assigned at the time a provider is added as a new user to RPMS and denotes the provider's discipline.
Queuing	Requesting that a job be processed at a later time rather than within the current session.
Return key	Press the Return key to show the end of an entry such as a number or a word. Press the Return key each time you respond to a computer prompt. If you want to return to the previous screen, simply press the Return key without entering a response. This will take you back to the previous menu screen. The Return key on some keyboards are shown as the Enter Key. Whenever you see [RET] or the Return key, press the Return or Enter Key.
Routine	A program or sequence of instructions called by a program that may have some general or frequent use. MUMPS routines are groups of program lines that are saved, loaded, and called as a single unit via a specific name.

Term	Definition
RPMS	Resource and Patient Management System; a suite of software packages used by IHS
Select	To choose one option from a list of options.
Site Manager	The person in charge of setting up and maintaining the RPMS System at the facility or area level.
Submenu	A menu that is accessed through another menu.
Text Editor	A word processing program that allows you to enter and edit text.
Trauma	An injury (wound) to living tissue caused by an outside force
Triage	Sorting patients by the urgency of their need for care
UCI	User Class Identification: a computing area.
Up-Hat (^)	A circumflex, also know as a "hat" or "caret," that is used as a piece delimiter in a global. The up-hat is denoted as "^" and is typed by pressing Shift+6 on the keyboard.
Utility	A callable routine line tag or function. A universal routine usable by anyone.
Variable	A character or group of characters that refers to a value. MUMPS recognizes 3 types of variables: local variables, global variables, and special variables. Local variables exist in a partition of the main memory and disappear at sign-off. A global variable is stored on disk, potentially available to any user. Global variables usually exist as parts of global arrays.
Walk-In	A patient who walks into a medical facility seeking care but who does not have an appointment.
Word Processing Field	This is a field that allows you to write, edit, and format text for letters, MailMan messages, etc.

17.0 Contact Information

If you have any questions or comments regarding this distribution, please contact the ITSC Help Desk by:

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